PSY388 Abnormal Behaviour mock exam - Final

Psychology: Abnormal Behaviour (Murdoch University)

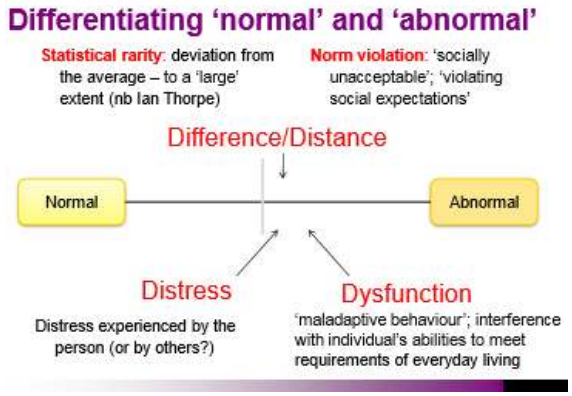
Scan to open on Studocu

Studocu is not sponsored or endorsed by any college or university
Downloaded by moin khan (moinamb99@gmail.com)

SHOUT
SHARE
IT

PSY388 – Psychology – Abnormal Behaviour Mock Exam

Chapter 1 Conceptual issues in abnormal psych


Differentiating 'normal' and 'abnormal'
Statistical rarity: deviation from the average – to a 'large' extent (nb Ian Thorpe)
Norm violation: 'socially unacceptable'; 'violating social expectations'
Difference/Distance
Normal
Abnormal
Distress
Distress experienced by the person (or by others?)
Dysfunction
'maladaptive behaviour'; interference with individual's abilities to meet requirements of everyday living

1. **When writing a case study example what should your answer always consider?**
   i. Define terms
   ii. Biopsychosocial perspective
   iii. Where on the spectrum from normal to abnormal difference (distance) distress (dysfunction)
   iv. Statistical rarity, norm violation (deviance), distress and dysfunction (maladaptive behaviour)
   v. Triple vulnerability model
   vi. Substantial impairment in social, occupational or other areas of functioning.

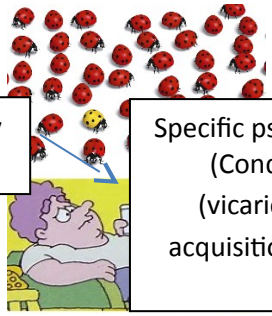
ANXIETY DISORDER

Generalised psychological vulnerability (world is not a safe place)

2. What are the four main criteria for differentiating abnormal from normal behaviour?

There is no universally accepted definition of abnormality, the common approach is to consider these four elements:

Statistical rarity (stats) – individual who possess a characteristic that is rarely found in society – a large



Generalised biological vulnerability (genes & in utero environmental)

Specific psychological vulnerability (Conditioning/ modelling (vicarious) and information acquisition..e.g. fear of dog/dog bite

Deviance or norm violation (value) – a behaviour is considered abnormal if it is deemed socially unacceptable. Does not include genius as this is ll antisocial behaviours criminal behaviour etc.. rement otherwise it can onformist behaviour (i.e.

Distress (self-defined) - Causes distress to the person, which can be problematic as mania for example does not cause distress

Dysfunction (Maladaptive) – interfering with a person's ability to meet requirements of everyday life (employment, family, social relationships and financial security). Key defining element of abnormality for health professionals but also socially bound and social expectations may be wrong.

3. What is the prevalence of mental health problems in Australia

Whilst Australia does not monitor mental health, according to the ABS National Survey of Mental Health & Wellbeing, 2007 there is a 12 months prevalence of 1 in 5 Australians and a Lifetime prevalence 47% of Australians

4. What is the definition of a clinically significant disorder?

A clinically significant disorder is one that causes substantial impairment in social, occupational or other areas of functioning.

This document is available on studocu

Downloaded by moin khan (moinamb99@gmail.com)

5. What is the quantifiable impact of mental health issues in Australia

i. $8 billion of health-related services in 2013/2014
ii. 6-7 deaths per day due to suicide in 2013
iii. Over 2 million patient bed days per year (2013-2014)
iv. 30% of all health costs for ages 15-44 years
v. Estimated: lost 6 million work days/yr. due to depression (MHCA)
vi. Total government expenditure on mental health increased by 178% from 1992-2011 (increased by $4.2 billion) however research is poorly funded
vii. Social impact is so extensive; it has not been estimated.

6. How does Wakefield's conception of "harmful dysfunction" help to differentiate the concept of mental disorder and social deviance?

Social deviance must be differentiated from mental disorders (clinically significant disturbance in an individual's cognition, emotion regulation or behaviour that reflects a dysfunction in the psychological, biological or developmental processes underlying mental functioning, as defined by the DSM V) to ensure diagnosis is not used as a form of oppression of non-conformist behaviour. Wakefield provides a conceptualisation of mental disorder that provides mid ground between a value judgement based on the individual and a definition of dysfunction that is not bound to social rules:

i. A factual component = internal dysfunction present= a psychological mechanism has failed to carry out its natural evolutionary function, for example the presence of anxiety in the absence of objective danger
ii. A value component/judgement = it needs to be causing harm to the individual, for example a psychic's visions do not cause them harm so would be evaluated positively.

7. What are the criticisms directed at Wakefield's harmful dysfunction conceptualisation?

It is difficult to determine the evolutionary function of psychological processes, for example 'sadness', and identifying when the process has failed. Also some functions are evolutionarily recent, such as reading and therefore reading disorders could not be classified as a disorder.

8. What is the aim of psychiatric classification?

The aim of psychiatric classification is to describe clusters of symptoms (syndromes) that have common causes and respond to common treatment, which are then labelled disorders. This is consistent with the medical model (biological perspective).

9. What two factors are the focuses of contemporary biological theories of medical disorders?

Structural brain abnormalities and neurochemical imbalances

10. Describe the causation, classification, and treatment from psychoanalytic perspective

Psychoanalytic treatment aims to bring the unconscious causes of conflict into conscious awareness. According to psychoanalytic theory all behaviour, normal or abnormal, results from the conflict between the id, the ego and the superego. Where the id conflicts with itself or threatens to overwhelm the ego, anxiety arises. To overcome this anxiety, the ego will employ defence mechanisms such as repression, denial and rationalisation, where these fail the result is significant distress.

Conditions are classified as:

i. psychosis – serious manifestations of neurosis without physical cause involving loss of contact with reality, including hallucinations and delusions
ii. neurosis – maladaptive symptoms causes by unconscious conflict and its associated anxiety, no clear line between normal and abnormal behaviour

Downloaded by moin khan (moinamb99@gmail.com)

11. What are the ways in which the classification of psychological disorders (e.g. depression) differ from the classification of medical disorders (e.g. Cancer)?

i. Are best described as continuous – between normality and abnormality
ii. Are not clearly distinguishable from one another (i.e. anxiety and depression) unlike cancer and the common cold

12. Describe the behavioural perspective for mental disorders

The behavioural approach rejects unobservable constructs and states that the causes of behaviour are observable and identifiable in the immediate environment. Through principles of learning, the causes of mental disorders are simply stimuli that elicit, reinforce or punish behaviour.

13. Describe the classical conditioning paradigm (Pavlov/ Watson)

In behaviourism, classical conditioning theory involves learning a new behaviour via the process of association whereby two stimuli are linked together to produce a new learned response without conscious awareness. Much human behaviour are governed by classical conditioning including meal time preference, going to the bathroom on waking, feeling happy going to a party and sad at a funeral. This reflects the human ability to record statistical regularity of what goes with what. There are three stages of classical conditioning.

14. Describe operant conditioning (B F Skinner)

Operant conditioning revolves around the central principle that all animals and humans like to repeat the behaviours that they get rewarded for (reinforcement) and avoid those that they are punished for (punishment) that the consequences of behaviour influence the likelihood that the behaviour will be repeated (Antecedent-behaviour – consequences) –recognises individual characteristics and conscious motives that come into play unlike classical conditioning models.

15. Describe the causation, classification, and treatment of abnormal behaviour from behavioural perspective

Abnormal behaviour is the result of maladaptive learning, for example fearing all dogs or even parks after a dog bite. In common (in this point alone) with psychoanalytic theory, the behavioural perspective sees normal and abnormal behaviour on a continuum. Behaviourists are critical of diagnostic categories; there are no underlying disease states but outcomes of the same learning processes.

Treatments include aversion therapies (such as the drug therapy Antabuse to create an aversion to alcohol), systematic desensitisation (cue exposure therapies) and token economies (operant conditioning - providing rewards for behaviour change).

16. Describe the causes and treatment of mental disorders from the cognitive approach (Ellis and Beck)

Cognitive theories focus on dysfunctional ways of thinking as the causes emotional distress and behavioural disturbances. This can be described using the A-B-C model

A= event – “friend didn’t sit next to me in class”

B = Interpretation of the event “ she was in a hurry” or “I’ve done something wrong”

C = Reaction to the event “no distress, chat after class” or “feel upset and run away to avoid repeated rejection”

Through cognitive restructuring clients are assisted to change dysfunctional thinking patterns to those which are more realistic and helpful.

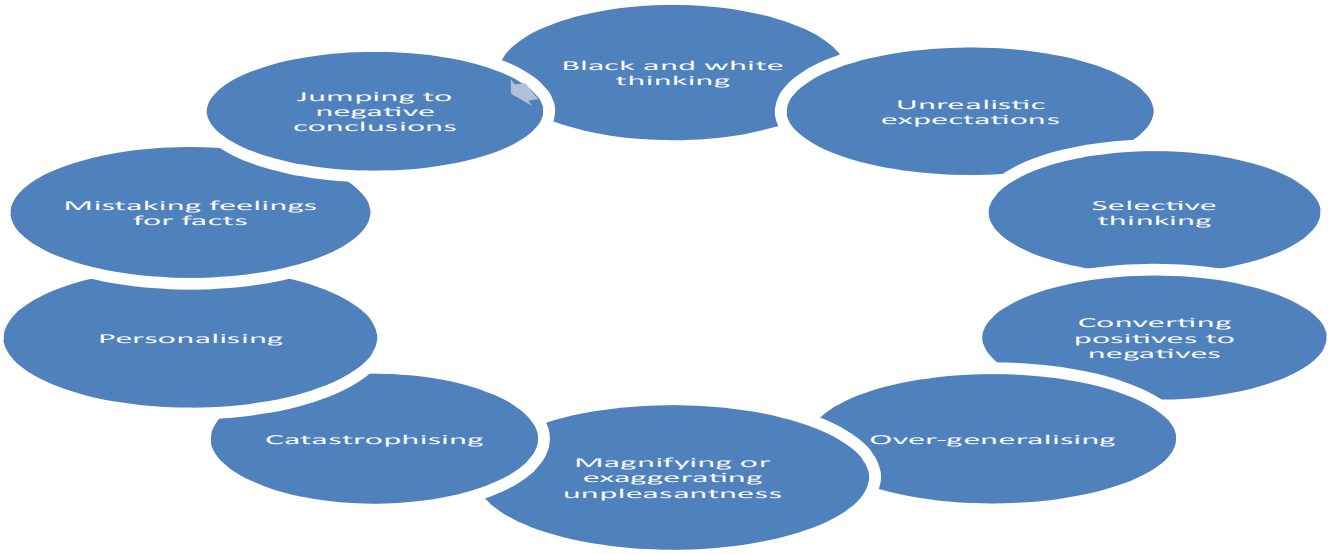
17. How do people displaying the cognitive distortion “black and white thinking” evaluate experiences?

People displaying black and white thinking evaluate experiences as either all good or all bad

This document is available on studocu

Downloaded by moin khan (moinamb99@gmail.com)

18. Name 10 cognitive distortions, such as those identified by Beck, occuring in individuals with psychological disorders



19. Describe cognitive behaviour therapy

A form of therapy combining cognitive and behavioural techniques, found to be more enduring than drug therapies for anxiety and mood disorders. CBT sets clear measurable goals and monitors them throughout the course of therapy. However, it should be noted that negative cognitions may be a result and not a cause of a psychological disorder.

20. How is the "scientist-practitioner model" best described?

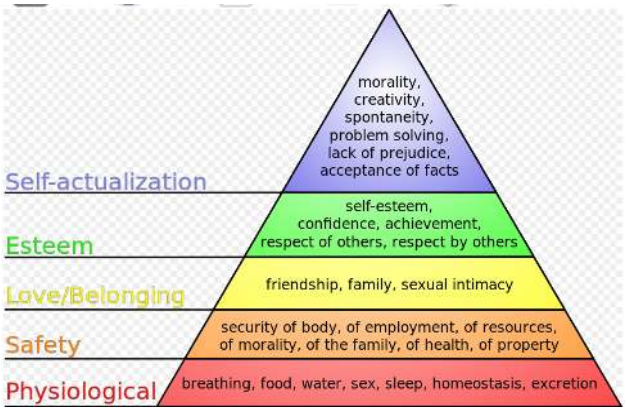
The scientist-practitioner model states that clinical practice and research should be informed by a scientific perspective.

21. Describe the humanistic perspective

According to the humanistic perspective (Carl Rogers/Maslow) people have a natural tendency towards growth and **self-actualisation**, fulfilling one's potential. Self-actualisation can be thwarted by insufficient **unconditional positive regard**, which is often only received if **conditions of worth** are satisfied.

Therapy is conducted in a **therapeutic alliance** characterised by mutual trust and shared goals. Concepts of humanistic theories are difficult to measure or falsify, but the humanistic perspective has become influential in personal development.

Maslow's Hierarchy of Needs


morality, creativity, spontaneity, problem solving, lack of prejudice, acceptance of facts
Self-actualization
self-esteem, confidence, achievement, respect of others, respect by others
Esteem
friendship, family, sexual intimacy
Love/Belonging
security of body, of employment, of resources, of morality, of the family, of health, of property
Safety
breathing, food, water, sex, sleep, homeostasis, excretion
Physiological

22. Describe the socio-cultural perspective

Socio-cultural perspectives argue that abnormal behaviours are best understood in terms of the social environment of the individual, family functioning, social networks, access to social resources, cultural values, religious and spiritual beliefs. Community psychology and social work have made important contributions from the sociocultural perspective.

23. What is the biopsychosocial approach?

Downloaded by moin khan (moinamb99@gmail.com)

The biopsychosocial approach holds the view that biological, psychological and social factors contribute to the development of abnormality. Most contemporary theories tend to be variants of the **vulnerability stress model (diathesis-stress model)** which explain the causation of psychological disorders as resulting from interaction between psychological vulnerability, individual biology and life event.

24. What are the advantages and disadvantages of diagnosis?

Advantages

- Diagnosis improves communication among mental health professionals
- Provide a description of specific disorders in a way that clarifies their features and boundaries from other disorders
- Helps researchers and clinicians communicate with each other regarding causes and treatments for individuals experiencing certain patterns of thoughts, feelings and behaviours.
- Provides ease of communication with wider society, including administrative concerns such as insurance, funding and data collection.

Disadvantages

- Widespread use of labels, intended to be descriptive terms rather than explanations, reifies them = making them widely perceived as an actual thing rather than a constellation of symptoms
- Mental disorders are theoretical constructs and are not independent of changing social values and theories (ie homosexuality and draptomania)
- May be harmful to people to be labelled and stigmatised as "mentally ill"

25. What are the limitations of the categorical system of classification reflected in DSM III and beyond

Due to the presence of a high rate of comorbidity it is difficult to study the nature, causation and treatment of individual disorders. This also calls into question the validity of separate independent diagnostic categories unlike diseases in the medical model which can be clearly differentiated.****difficulty of differential diagnosis*****

26. How did the DSM V introduce a dimensional diagnostic system?

Prior to the introduction of DSM V the cut of point on the severity continuum was arbitrary; therefore DSM V added a dimensional scale (mild, moderate or severe) to the usual categorical diagnosis taking a small step towards a dimensional diagnostic system. The ultimate aim of dimensional models of psychopathology is to replace the many categories with a small number of basic dimensions, for example anxiety, depressive and bipolar disorders are proposed to exist on a continuum of increasing severity rather than different disorders. At this stage these conditions are instead listed in the same chapters of the DSM V manual.

27. The DSM-5 is based on the:
a) medical model.☺
b) psychological model.
c) stress-diathesis model.
d) sociocultural model.
e) humanistic model.

28. Humanistic theories and therapies are not:
~~a) easy to measure and evaluate.☺~~
b) used widely in counselling.
c) influential in the personal growth movement.
d) inclusive of human individuality and choices.
e) non-pathologising of the individual.

29. A functional analysis of behaviour:

40. A mental disorder is a syndrome characterised by:
a) extreme anger.
b) heightened sensations.
c) disturbances in social skills.
d) disturbances in cognitions and behaviour.☺
e) depression.

41. The pattern and rates of co-occurrence among the mental disorders are thought to reflect:
a) the presence of personality disorders.
b) separate, independent causation.
c) the existence of higher order dimensions of psychopathology.☺
d) classical conditioning.
e) clinical bias.

42. Which of the following is not one of the reasons experts

This document is available on studocu
Downloaded by moin khan (moinamb99@gmail.com)

a) describes behaviour and its environmental determinants objectively.☺
~~b) reduces incongruence and results in self-actualisation.~~
~~c) interprets behaviour in terms of unconscious conflicts.~~
~~d) associates a relaxation response with imagined feared stimuli.~~
~~e) connects behavioural responses to cognitive distortions.~~

30. Which of the following does not form part of the definition of abnormal behaviour?
a) rarity
b) treatment☺
c) distress
d) dysfunction
e) norm violation

31. Which does not typically form part of cognitive-behavioural treatment?
a) cognitive restructuring
b) behavioural experiments
c) dream analysis☺
d) thought diaries
e) altering behaviours

32. With reference to Wakefield's 'harmful dysfunction' analysis of mental disorders, what is 'dysfunction'?
a) where a psychological process has failed to carry out its natural function ☺
b) where an individual is unable to function in society
c) where an individual is behaving in a threatening manner
d) where an individual is unable to empathise
e) where an individual is unable to relate to others

33. The rational–emotive therapist Ellis believed that people respond to:
~~a) their conditioning.~~
b) their interpretations of events.☺
~~c) social expectations.~~
~~d) modelling.~~
e) ~~interpersonal relationships~~.

34. Critical psychologists argue that:
a) mental health professionals can be agents of oppression.
b) social perspective is neglected in mental health services.
c) abnormal behaviour must be considered within its context.
d) All of the given options are correct.☺
e) None of the given options are correct.

35. As a psychiatrist treating patients, Aaron Beck noticed repeated patterns which he labelled as:
a) cognitive distortions.☺
~~b) defence mechanisms.~~
~~c) systematic desensitisation.~~
~~d) conditioned responses.~~
~~e) rational behaviours.~~

36. Prior to the twentieth century, the concept of mental illness was virtually identical to the concept of:
a) sin. C) retardation d) paralysis
b) neurosis. E) insanity☺

37. The DSM-5 adopted what approach in its classification of have proposed a dimensional system of classification for DSM-5?
a) Psychiatric disorders are shown to exist on a continuum of severity.
~~b) Psychiatric disorders are separate and independent.☺~~
c) There are high rates of comorbidity among psychiatric disorders.
d) The point on a continuum at which a diagnosis is made is largely arbitrary.
e) It may improve the validity of the diagnostic system.

43. According to Carl Rogers, the main determinant of whether people fulfil their potential is whether or not they have experienced which of the following?
~~a) empathy~~
~~b) client-centred therapy~~
~~c) positive reinforcement~~
~~d) supportive family relationships~~
e) unconditional positive regard☺

44. Which of the following does Maslow's hierarchy of needs <u>not</u> include?
a) safety
b) warm relationships with other people
c) self-actualisation
d) basic biological needs
e) social skills☺

45. The Diathesis-Stress Model explains mental disorders in terms of:
a) brain abnormalities.
b) an interaction between biological and psychological factors.☺
c) neurotransmitter imbalance.
d) adverse life events.
e) personality types.

46. The fact that not everyone will develop an affective disorder after the loss of a loved one is best explained by:
a) the 'harmful dysfunction' model.
b) the Diathesis–Stress Model.☺
c) genetics.
d) upbringing.
e) societal expectations.

47. Which of the following is not true of ECT?
a) It was found to be an effective treatment for severe depression.
b) It is still used today.
c) It was developed in the 1930s.
d) It was found to have a calming effect on patients.
e) The way it works is well understood.☺

48. The behavioural perspective considers all behaviour, both normal and abnormal as the product of:
a) genetics.
b) brain abnormalities.
c) neurotransmitter imbalance.
d) learning☺
e) hormone deficiency.

49. Most modern explanations of mental disorder include:

Downloaded by moin khan (moinamb99@gmail.com)

disorders?

a) a psychoanalytic approach
b) a neo-Kraepelinian approach☺
c) an eclectic approach
d) a causation approach
e) a theoretical approach

38. Behaviourists and psychoanalysts agree that:

~~a) learning explains most problem behaviours.~~
~~b) unconscious conflicts explain most problem behaviours.~~
~~c) therapy commences with functional analysis.~~
d) normal and abnormal behaviours are on a continuum.☺
~~e) problematic family relationships explain most psychopathology.~~

39. The key issues raised in the construction of DSM-5 include all of the following except:

a) a rating system indicating the extent and quality of empirical research.
b) explicit guidelines for changing criteria from one edition of the DSM to the next.
c) the possibility of a dimensional approach.
d) the inclusion of a psychoanalytic perspective.☺
e) All of the options are key issues relevant to the construction of DSM-5.

a) an evolutionary model.
b) a categorical model.
c) a continuum model.
d) a Diathesis-Stress Model.☺
e) a Family Systems Model.

50. The dimensional approach to mental disorders argues that disorders:

a) are categorical in nature.
b) are co-morbid.
c) exist along a continuum.☺
d) are arbitrary.
e) are socially constructed.

51. Which one of the following has <u>not</u> been suggested to be an advantage of using both a categorical and a dimensional system of diagnosis for psychiatric disorders?

a) Clinicians will find the combination system simpler to use than the current system. ☺
b) Clinicians can still use familiar categories to facilitate efficient communication.
c) Clinicians can use the dimensions to identify a patient's strengths and weaknesses.
d) Clinicians will be able to use the dimensional approach to assess initial severity.
e) Clinicians can use the dimensions to note changes in severity during treatment.

Chapter 2 Anxiety, OCD and trauma related disorders

52. Looking at anxiety disorders as a whole what do we know about prevalence?

1 in 4 Australians will experience an anxiety disorder in their lifetime, only 20-30% of these people seek treatment, more common in women than men (biological reasons, cultural pressure on women, more likely to report it than men)

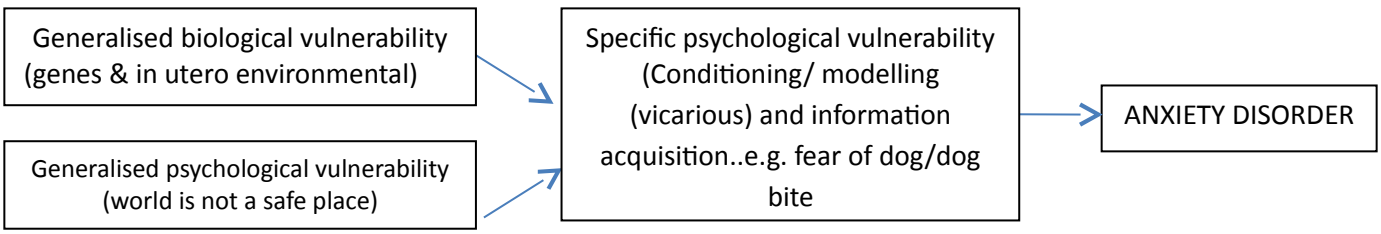
53. What are the primary features of an anxiety disorder?

The key feature of anxiety disorder is false alarm, the appearance of anxiety symptoms without any recognisable stimulus or when the stimulus does not warrant such a reaction leading to abnormal or inappropriate anxiety.

i. Biological factors – ie. Inherit predisposition to towards anxiety and depression ('general neurotic syndrome')
ii. Generalised psychological factors – belief that "the world isn't a safe place and you have no control over it"
iii. Specific psychological factors – conditioning and vicarious acquisition of fear through modelling

54. Describe the triple vulnerability model (Barlow, 2002)

The triple vulnerability model emphasises similarities between various anxiety disorders. Three areas of sensitivity to alarm have been identified which lower the threshold for false alarm:

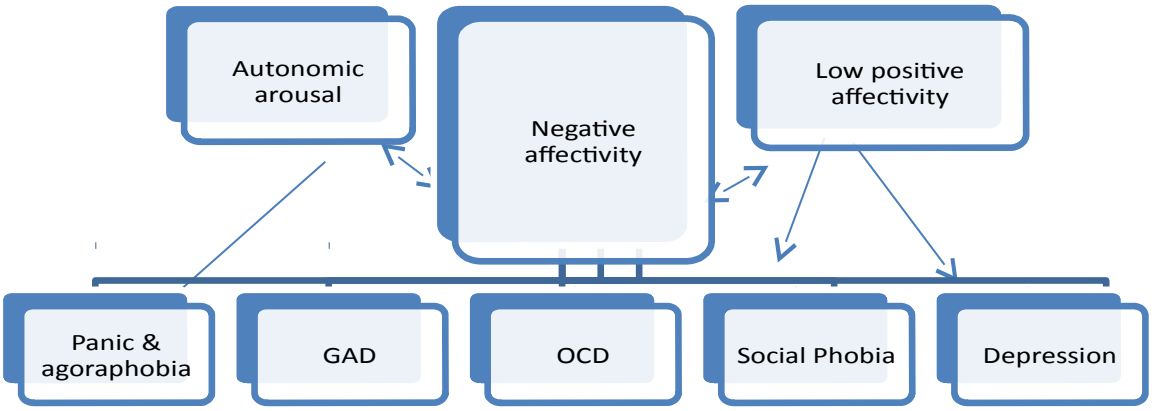

Generalised biological vulnerability (genes & in utero environmental)
Generalised psychological vulnerability (world is not a safe place)
Specific psychological vulnerability (Conditioning/ modelling (vicarious) and information acquisition..e.g. fear of dog/dog bite
ANXIETY DISORDER

Specific vulnerabilities are thought to be more strongly associated with, and play a more important role in maintaining <u>particular</u> disorders.

55. Describe Brown and Barlow's dimension of emotions across anxiety disorders and depression

This document is available on studocu
Downloaded by moin khan (moinamb99@gmail.com)

Where the triple vulnerability model emphasises similarities between disorders dimension of emotion models consider both similarities and differences in the three dimensions of emotion and how these differ across anxiety disorders and depression.

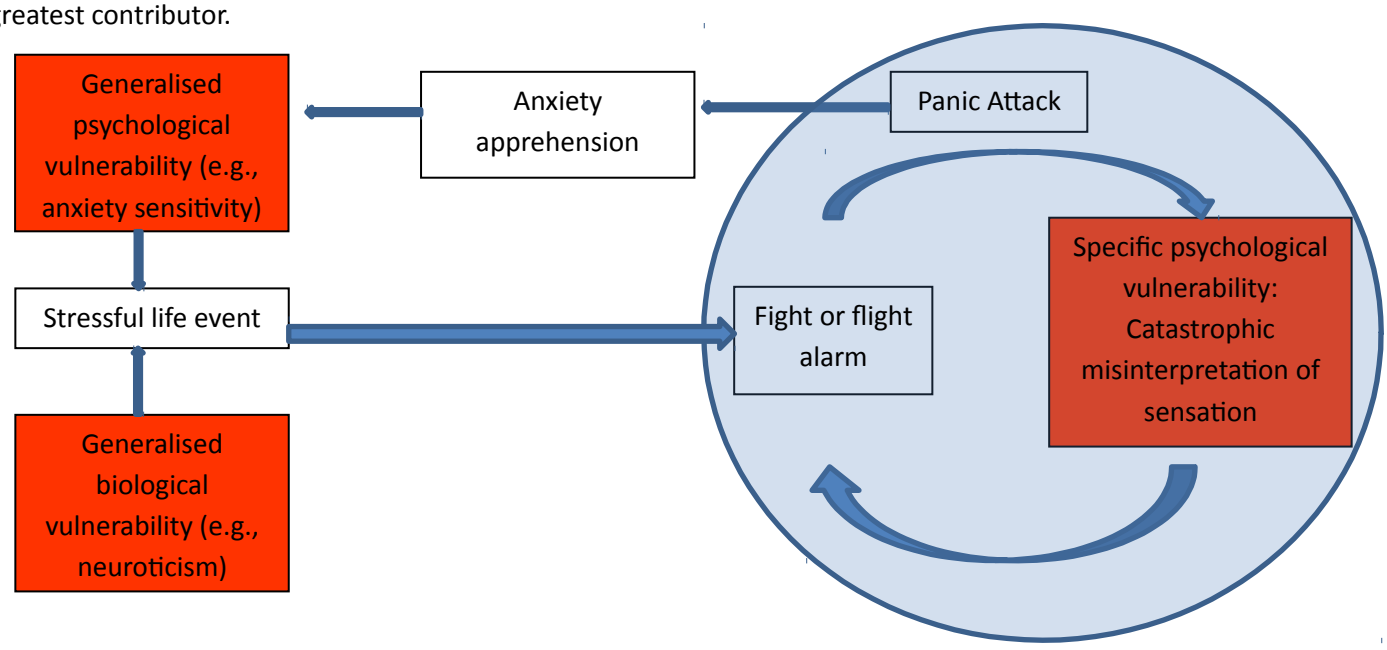


56. What is a panic attack?

A panic attack is an episode of acute physiological and cognitive symptoms of intense fear and discomfort, acute activation of the sympathetic nervous system and HPA axis. 10% of the population experience a panic attack at some point.

57. Explain the psychological vulnerabilities that are important in affecting whether individuals who experience panic attacks go on to develop panic disorder

Based on Barlow's triple vulnerability model the development of panic disorders arising out of panic attacks relates to all three aspects of the triple vulnerability model, though specific psychological vulnerability is the greatest contributor.


Generalised psychological vulnerability (e.g., anxiety sensitivity)
Anxiety apprehension
Panic Attack
Stressful life event
Fight or flight alarm
Specific psychological vulnerability: Catastrophic misinterpretation of sensation
Generalised biological vulnerability (e.g., neuroticism)

The model shows that past panic attacks lead to anxiety apprehension feeding into anxiety sensitivity (belief that the physical manifestation of anxiety has harmful consequences). In the presence of a stressful life event this generalised psychological vulnerability, together with generalised biological vulnerability such as neuroticism, trigger alarm at a lower rate of stress intensity. Once the fight or flight response has been triggered the specific psychological vulnerability of catastrophic misinterpretation of sensation feeds back to further boost the autonomic nervous system response creating a loop which leads to panic, beginning the process anew and increasing the likelihood of the development of panic attacks leading to panic disorder.

Downloaded by moin khan (moinamb99@gmail.com)

58. Define what is meant by safety behaviours and how can they serve to maintain an anxiety disorder? Describe using an example of an individual with social anxiety disorder

Safety behaviours, common in anxiety disorders, are subtle avoidance behaviours used in a misguided attempt to prevent a fear from coming true. Individuals mistakenly attribute the non-occurrence of their feared outcome to their use of the safety behaviour, which prevents them from learning that their fear was unlikely to occur even without the safety behaviour. For example someone with social anxiety disorder may use avoidance behaviour such as not joining in a conversation to avoid being thought a fool, when in fact it is doubtful their contribution to the conversation would be so judged.

59. What is the startle reflex?

The startle reflex, fear of loud noises, is displayed from birth (unlearnt fear) and intensely anxious people such as those suffering from PTSD experience a stronger startle reflex. Loud noises activate a path from the cochlea to cells in the pons that trigger a tensing of neck and other muscles.

The startle reflex is the extremely fast response, within 2/10ths of a second, to unexpected loud noise, found unlearned in young infants. The startle reflex can be suppressed by a weak “pre-pulse” 50 ms before the main stimulus that can be used as a measure of inhibitory control and differs across psychopathologies.

The Startle reflex can be tested by measuring action potentials generated within the orbicularis oculi muscle (the muscle that closes the eye during a blink), with surface or needle electromyographic (EMG) recording electrodes.

60. What is the connection between neuroplastic changes and PTSD

PTSD suffers have lower than normal cortisol levels after the trauma, the factor that closes the loop of the HPA axis, turning off the stress response after reaching the amygdala. The amygdala, which is associated with the processing of emotions such as fear. People with low cortisol are ill-equipped to combat stress and more prone to its damaging effects. Prolonged stress can be harmful to the hippocampus, with glucocorticoids having neurotoxic effects and can effect memory with studies showing PTSD suffers having a smaller than average hippocampus. Stress impairs the adaptability and the production of new hippocampal neurons. People with PTSD have also been found to have a stronger startle reflex.

In response CBT aimed at enhancing extinction, has seen to be more effective when preceded by the use of an NMDA agonist, targeting NMDA receptors in the basolateral amygdala association with the process of extinction.

61. Which of the following is not a change to anxiety disorders in the DSM-5?

a) There is a minimum period to receive a specific phobia diagnosis.
b) Agoraphobia has become a distinct disorder from panic disorder.
c) A distinction is made between performance social phobia and generalised social phobia.
d) OCD is listed within 'Anxiety and Obsessive-Compulsive Spectrum'.
e) Specific phobia and panic disorder are combined into one diagnosis.

62. In the DSM-5, OCD is now grouped with related disorders. Which of the following is not a related disorder?

a) body dysmorphic disorder
b) hoarding disorder
c) generalised anxiety and worry disorder
d) trichotillomania
e) excoriation (skin-picking)

This document is available on studocu

Downloaded by moin khan (moinamb99@gmail.com)

Downloaded by moin khan (moinamb99@gmail.com)

	Aetiology	Treatment
Biological Presentation **DSM-5: Criteria** **Psychological Progression**	**Generalised Anxiety Disorders** **Prevalence** / **Age of onset** / **Gender difference** most common anxiety disorder with a lifetime prevalence of 5% / Early age of onset / Women: men 2:1 (caregiving nature of women's role in society). Chronic worry, daily life which is difficult to control and not easily dismissed for a period of at least 6 months accompanied by physical symptoms of tension, such as irritability, fatigue, difficulties concentrating, sleep problems, restlessness, agitation and muscle tension. **Predisposing Factors (vulnerabilities):** ➢ Whilst a moderate genetic disposition for GAD ➢ Inherit predisposition to towards anxiety ('general neurotic syndrome') ➢ Stress reactivity, limbic hypersensitivity, anxiety sensitivity **Precipitating factors (Stressors):** ➢ Physiological Arousal which interacts with psychological factors ➢ Inability to control worry **Predisposing Factors (vulnerabilities)** Early age of onset and chronic course, unlikely to improve without treatment. ➢ Generalised psychological factors – global (versus specific) i.e. belief that "the world isn't a safe place and you have no control over it" **Precipitating factors (Stressors):** ➢ Trauma ➢ Specific psychological factors – conditioning and vicarious acquisition of fear through modelling **Perpetuating factors (maintaining):** ✓ cycle of anxiety about anxiety – fearing the autonomic response ✓ Perceived distress/ dysfunction ✓ False alarms ✓ Excessive worry **Theories:** **Information processing model – ('constant vigilance")** people with GAD selectively attend to cues for danger, as demonstrated by the stroop task (words such as green and written in blue but the correct response is "blue" when asked what colour it is) where it takes longer for a person with GAD to say red after seeing the word DANGER than it would take them to say red after the word DAISY. **Wells Meta-cognitive model – ("people with GAD have positive and negative beliefs about worry").–** centres on meta-beliefs, our beliefs about our own beliefs including negative meta-beliefs or worrying about worry "my worries will drive me crazy" **Avoidance theory of worry – ('we worry to avoid fears or concerns'**) states that we worry to avoid the anxiety of distressing images or core underlying fears and concern. For example by concentrating our minds (verbal-linguistic) on worry about something we are avoiding mental imagery of a distressing image or a belief such as "I am inadequate" past events and childhood trauma. **Intolerance of uncertainty model ('Need for control')–** people with GAD are said to be intolerant of even mild amounts of uncertainty and will attempt to control situations that are associated with uncertain outcomes (i.e. do things perfectly).The theory states a. Worry is a coping mechanism b. GAD sufferers have 'poor problem orientation' (look for uncertainty) and low confidence in capacity, c. worry acts to reduce distressing mental images	Psychoactive Medications; SSRI's found to be a better option than Benzodiazapines (addictive), Mindfulness – found to be more effective than CBT though combined therapy is also beneficial. Biofeedback (relaxation, breath training) **Cognitive behaviour therapy = 50% of people show measurable improvement** –Includes psychoeducation relaxation training, challenging unhelpful thoughts, behavioural experiments, reducing unhelpful coping strategies, worry exposure, seeking and testing beliefs with graded exposure
Comorbidity • One of the most common comorbid conditions with other disorders • MDD – shares common genetic diasthesis • Other anxiety disorders such as panic	**Dysfunction** ➢ Found to be as debilitating as MDD ➢ People with GAD who show less responsiveness on physiological measures such as heart rate, blood pressure, respiration, skin conductance, etc. than do people with other more general anxiety symptoms are referred to as autonomic restrictors.	
Social – Relationships (Micro &	**Predisposing Factors (vulnerabilities):** Parenting style **Precipitating factors (stressors)&**	Interpersonal psychotherapy –Addresses interpersonal problem that are believed to maintain the symptoms

This document is available on studocu
Downloaded by moin khan (moinamb99@gmail.com)

Social Anxiety Disorder/Social Phobia

Anxiety disorder characterised by an extreme shyness and fear of being judged or embarrassed in front of others, causing the individual to avoid social situations though avoidance of public places. Social phobia revolves around negative evaluation from others.

Prevalence	**Age of onset**	**Gender difference**
8% of lifetime prevalence Aust	½ of sufferers report onset by 12	General population 1.5 x more women, no difference in clinical population

DSM-5: Criteria

i. A diagnosis requires that a person's fear or anxiety be out of proportion—in frequency and/or duration—to the actual situation. The symptoms must be persistent, lasting six months or longer.

ii. The person must suffer significant distress or impairment that interferes with his or her ordinary routine in social settings, at work or school, or during other everyday activities

Progression Left untreated social anxiety will become chronic rather than episodic. If treated people can learn to communicate more effectively

Comorbidity	**Dysfunction**
• Comorbid depression rate is high	➢ Distorted assumed negative evaluation of others leads to false alarm

	Aetiology	**Treatment**
Biological	**Predisposing Factors (vulnerabilities):** ➢ Twin studies provide evidence of the contribution of genetic factors **Perpetuating factors (maintaining):** ➢ Panic attack – contribute to ongoing self-critical evaluation	Psychoactive medication: •Beta blockers - are ineffective , Tricyclic antidepressants: reduce social anxiety •MAOI: reduce anxiety SSRI Paxil: used for social anxiety disorder But ….. relapse rates are high following medication discontinuation
Psychological	**Predisposing Factors (vulnerabilities)** ✓ The core psychological vulnerability - distorted evaluation of the way viewed by others (unhelpful cognitions). ✓ Excessive self-focus with disproportionate focus on real or imagined failures in social situations – diverts attention from pro-social behaviours (smiling) **Precipitating factors (Stressors):** • It may develop due to an embarrassing event, i.e. wet your pants or panic attack. **Perpetuating factors (maintaining):** • reduced self-confidence leading to social withdrawal and increased anxiety in social situations and less opportunity to develop self-efficacy in these situations. • Based on the false belief that others are superior, A. conversation risks exposure so to speak risks rejection and shame to stay B. silent risks being seen as shy and uninteresting and again risks rejection and shame, guilt ➢ Use of safety behaviours – avoiding disorder may use avoidance behaviour such as not joining in a conversation to avoid being thought a fool, when in fact it is doubtful their contribution to the conversation would be so judged.	**Cognitive-behavioural treatment (CBT) is highly effective** •Exposure (imagery and real) •Rehearsal •Role-play (individual and group) •Challenge unhelpful cognitions. Video feedback is a useful technique to challenge negative self-images and false beliefs common to those with social anxiety disorder. Video feedback would provide evidence of competence and show that the symptoms they are fearful of displaying, such as shaking, sweating and blushing are not so evident as they imagine.
Social – Relationships	**Predisposing Factors (vulnerabilities):** **Precipitating factors (stressors)& Perpetuating factors:** ✓ associated with excessive parental criticism ✓ Learning from parents to be overly concerned with the opinions of other resulting in social withdrawal ✓ Dislike and rejection by others elicited by social withdrawal	

Downloaded by moin khan (moinamb99@gmail.com)

Specific Phobia

An anxiety disorder characterised by extreme fear of a specific object or situation, which results in the individual avoiding the object or situation. The focus of fear may be: an animal; something in the natural environment (heights storms etc.); blood, injections or injury; or situational (planes elevators etc.).

Prevalence	Age of onset	Gender difference
Lifetime 7-9%	Early childhood and adolescence and prevalence falls with age – might grow out of it	2:1 female to male

DSM-5: Marked (intense) consistent (almost every time trigger encountered) and persistent (period of at least six months) fear reaction in the presence of a trigger

Progression Less than 1% ever seek treatment and becomes chronic

Dysfunction False alarm - intense autonomic reaction in absence of danger Blood, injection or injury phobic's experience a decrease in blood pressure when faced with their fear, leading to fainting.

	Aetiology = Barlow's Triple Vulnerability Model
Biological	**Predisposing Factors (vulnerabilities):** ➢ Generalised biological vulnerability - Inherit predisposition to towards anxiety ('general neurotic syndrome') ➢ Phobias may have biological basis in their evolutionary significance
Psycho	**Precipitating factors (Stressors):** ✓ Negative encounters leading to a classically conditioned response (bitten by a dog) – but most people don't recall an aversive event **Perpetuating factors (maintaining):** ✓ Conditioned response
Social	**Precipitating factors (stressors)** ✓ Indirect/vicarious learning pathways (someone is else is scared of spiders)
Treatment	**in vivo exposure therapy is the most effective treatment for specific phobias– exposure (imagined, virtual reality or real life) leads to elimination of classically conditioned response through extinction (no longer associating seeing a dog and being bitten) and from increased self-efficacy from facing your fear**

This document is available on studocu

Downloaded by moin khan (moinamb99@gmail.com)

Post Traumatic Stress Disorder (PTSD)

Prevalence	Gender difference
around 4%.	Although men have been found to be more likely to experience a traumatic experience, women have a two-fold risk of developing PTSD

DSM-5: Trauma and stress related disorders

Criteria These symptoms (see dysfunction) must be present for at least one month.

Comorbidity	Dysfunction
• 59% MDD • 31% GAD • 25% Alcohol use disorder	i. Re-experiencing symptoms - - intrusive memories, flashbacks and nightmares ii. Avoidance symptoms – avoidance of thoughts or reminders of the trauma iii. Negative changes in cognitions and mood – emotional numbing, loss of recall of aspects of the traumatic event or excessive blaming and negative effective states (fear, anger, guilt, and shame) iv. Marked alteration in arousal – includes exaggerated startle response, hypervigilance (on the lookout for danger), sleeping and concentrating difficulties, outbursts of reckless, destructive behaviours or anger.

	Aetiology	Treatment
Biological	**Predisposing Factors (vulnerabilities):** ➢ female gender **Perpetuating factors** ➢ PTSD suffers have lower than normal cortisol levels after the trauma, ➢ HPA axis dysregulation from extreme sympathetic nervous system response	CBT aimed at enhancing extinction, has seen to be more when preceded by the use of an NMDA agonist, targetin receptors in the basolateral amygdala association with the p extinction.
Psychological	**Predisposing Factors (vulnerabilities)** ➢ comorbid psychological condition, prior trauma, lower intelligence, the severity of the trauma. **Precipitating factors (Stressors):** ➢ PTSD occurs as a result of a single traumatic event **Theories:** **Cognitive model =** interpretation paced on traumatic event "I deserved it" "never feel safe again" **Learning – classical conditioning** reminders trigger fear responses	CBT therapies (50% of PTSD suffers, 50% dropout rate) such as Psychoeducation – providing education related to physiolo psychological symptoms Anxiety management – coping skills and relaxation techniques Cognitive restructuring – correcting maladaptive cogniti interpretations Prolonged imaginal exposure – vivid imaginable techniques event for at least 50mins ***led to greatest results*** PREVENTION: If these therapies are introduced two wee trauma they reduce the chances of PTSD ever developing.
Social – Relationships (Micro & meso systems)	**Predisposing Factors (vulnerabilities)** ➢ lower social support, ongoing related stressors (i.e. after a natural disaster) **Precipitating factors (stressors)& Perpetuating factors:** The more interpersonal the violence (rape versus accident) the more likely PTSD will develop.	➢

Panic Disorder and Agoraphobia

Prevalence	Median Age of onset	Gender difference
3.5% panic disorders 2.3% agoraphobia.	30 years panic and 22 years agoraphobia	Panic = somewhat more female Agoraphobia, severity and females are positively correlated

Downloaded by moin khan (moinamb99@gmail.com)

DSM-5: Criteria Panic disorder is an anxiety disorder characterised by recurrent, unexpected panic attacks, with at least one month of persistent concern or worry about panic attacks or their consequences plus significant behaviour change due to attacks (i.e. Interoceptive avoidance such as avoiding exercise).
Agoraphobia is an anxiety disorder characterised by fear of situations in which it would be difficult to escape or in which help might not be readily available (such as in enclosed spaces or crowds) in the event of experiencing panic symptoms (so not fear of the agora but fear of having a panic attack there).
Agoraphobia is diagnosed when the sufferer experiences fear or anxiety in at least two of the following five situations

i. Using public transport
ii. being in open spaces (i.e. carparks and bridges)
iii. being in enclosed spaces (i.e. theatre or cinema)
iv. standing in a queue or being in a crowd
v. being outside of home alone

Progression Average duration before seeking treatment is 10 years, tends to be chronic

Comorbidity | **Dysfunction**

- ➢

	Aetiology Barlow's Triple Vulnerability Model	**Treatment**
Biological	**Predisposing Factors (vulnerabilities):** ➢ Generalised biological vulnerability - Inherit predisposition to towards anxiety ('general neurotic syndrome') **Perpetuating factors (maintaining):** ✓ Panic attacks ✓ Alcohol	Pharmacological therapy: Tricyclics, SSRI's and Benzodiazepines, but all have side effects The best long term outcomes for sufferers of panic disorder is CBT alone, with combined drug treatment and CBT found to have no long term advantage.
Psychological	**Predisposing Factors (vulnerabilities)** ✓ Generalised psychological vulnerability – anxiety sensitivity ✓ mistaken beliefs about anxiety **Precipitating factors (Stressors):** ✓ Stressful life events **Perpetuating factors (maintaining):** ✓ Anxious apprehension - Apprehension of panic attacks can be more anxiety provoking than the panic attack itself ✓ anxiety sensitivity = hypervigilance to physiological responses (interoceptive and exteroceptive avoidance) and "fear of fear" becoming anxious about anxiety ✓ Catastrophic interpretation of sensations *"I'm going to die"*	CBT - The best long term outcomes for sufferers of panic disorder is CBT alone. AIM to address phobic avoidance with in vivo exposures (imagined or real) **repeated and graded exposure** While behaviourist would state that interoceptive exposure relates to extinction of conditioned behaviour from a cognitive perspective by experiencing self-induced hyperventilation, for example, false beliefs are challenged and fears confronted. Self-efficacy, the subjective belief in your ability to cope, can be aided by exposure to the physical sensations of a panic attack in the absence of catastrophic consequences (i.e. no heart attack or panic attack or going crazy).
Social – Relationships	**Perpetuating factors:** ✓ role fulfilment - the sick role	➢

Obsessive Compulsive Disorder (OCD)

Prevalence	**Age of onset**	**Gender difference**	**Mortality**
lifetime risk in Australia of 4.6%.	Onset before age 18 most common	More common in men than women with gender differences in presentation.	

This document is available on studocu
Downloaded by moin khan (moinamb99@gmail.com)

DSM-5: Criteria

Whilst OCD can include infinite variations in presentation it must include:

i. Obsessions and/or compulsions (commonly including 'checking' and 'washing')
ii. Marked distress
iii. Must be time consuming
iv. Must interfere with occupational or social functioning
v. Not be a results of substance use or other medical condition

3 levels of insight recorded in the DSM V related to OCD

i. Good or fair insight
ii. Poor insight ("probably true" is argued)
iii. Absent insight ("it's true")

Progression May wax and wane over the lifetime and will rarely spontaneously remit

	Aetiology	Treatment
Biological	**Predisposing Factors (vulnerabilities):** ➢ **neurophysiological model** the OCD results from the failure of inhibitory pathways in the basal ganglia (involved in motor control). This, it is claimed by the supporter of the cognitive model, is an artefact of the condition not its aetiology.	➢ 40-60% of sufferers benefit from clomipramine a tricyclic that increases 5_HT circulation
Psychological	**Predisposing Factors (vulnerabilities)** ➢ **cognitive model** emphases the role of misinterpretation of intrusive thoughts (i.e. giving intrusive thoughts significance rather than ignoring them like the general population **Precipitating factors (Stressors):** **Perpetuating factors (maintaining):** ➢	CBT = treatment of choice. 75% of those with OCD treated with CBT received significant benefit, one example is exposure response prevention. Through a process of exposure to fear stimuli (object of obsession – dirt which will lead to serious illness) whilst preventing the person from engaging in the compulsive response to this stimuli (washing, changing clothes). Through this process beliefs about related harm are disconfirmed. ➢

63. Research supports the view that obsessional thoughts experienced by OCD sufferers are no different than those experienced by the general population. However, in OCD sufferers:

a) the obsessional thoughts are very negative.
b) the obsessional thought are very aggressive and/or sexual in nature.
c) the obsessional thoughts are awarded a special significance.
d) the obsessional thoughts arise 'out of the blue'.
e) None of the given options are correct

Downloaded by moin khan (moinamb99@gmail.com)

64. Which of the following is not a core feature of posttraumatic stress disorder?
a) mania ☺
b) avoidance of stimuli related to the trauma
c) symptoms of re-experiencing the trauma
d) increased arousal
e) exaggerated startle response

65. Which of the following is not a major symptom cluster in the definition of posttraumatic stress disorder?
a) arousal symptoms
b) avoidance symptoms
c) substance abuse symptoms ☺
d) re-experiencing symptoms
e) All of the given options are correct.

66. Which of the following is not true of cognitive behaviour therapy in the treatment of generalised anxiety disorder?
a) Treatment gains are maintained after therapy stops.
b) Clients are assisted to identify negative beliefs.
c) By the end of therapy, at most only 50 per cent of clients score in the non-clinical range on measures of symptoms.
d) Clients are taught to avoid and suppress their worries. ☺
e) Clients are taught to re-appraise negative predictions about threats.

67. The idea that specific phobias are classically conditioned is weakened by the fact that:
a) not all individuals show phobic responses after a negative encounter with a stimulus.
b) the majority of phobic individuals report no memory of a pairing of an aversive event with the phobic object.
c) phobic fears are not evenly distributed across possible stimuli.
d) All of the options listed here are correct.☺
e) None of the given options are correct.

68. People with obsessive-compulsive disorder are more likely to have a poor outcome if their symptoms include:
a) excessive concern about their appearance.
b) compulsive checking.
c) hoarding.
d) hand washing.
e) obsessional thoughts.

69. Which of the following is not typically true of

74. 1. Obsessive-compulsive disorder has a prevalence rate of about:
a) 2 to 3 per cent.☺
b) 1 per cent.
c) 0.2 per cent.
d) per cent.
e) per cent

75. 1Generalised anxiety disorder (GAD) has a lifetime prevalence of about:
a) 10 per cent.
b) 5 per cent.☺
c) 1 per cent.
d) per cent.
e) per cent.

76. Which of the following is not true of benzodiazepine medications in the treatment of generalised anxiety disorder?
a) They quickly reduce anxiety.
b) They produce drug tolerance and dependence.☺
c) They were frequently prescribed in the past.
d) The anxiety symptoms return after the medication is stopped.
e) The anxiety symptoms do not return after the medication is stopped

77. Research supports the hypothesis that _____ is/are a specific feature of generalised anxiety disorder.
a) intolerance of uncertainty☺
b) positive meta-beliefs about worrying
c) worry about a few closely related themes
d) over-estimating one's ability to cope with negative events
e) negative cognitions

78. According to the Wells Meta-Cognitive Model of generalised anxiety disorder (GAD), an individual with GAD is likely to have:
a) only positive beliefs about worrying.
b) only negative beliefs about worrying.
c) both positive and negative beliefs about worrying.☺
d) All of the given options are correct.
e) None of the given options are correct.

79. People with social phobia avoid situations because they fear:
a) panic attacks.
b) re-experiencing trauma.
c) contamination by other people.
d) enclosed spaces.
e) embarrassment and negative evaluation by other people.☺

This document is available on studocu
Downloaded by moin khan (moinamb99@gmail.com)

GAD?

a) GAD occurs more often in women than men.
b) Without treatment GAD has a chronic course.
c) It is not comorbid with other disorders. ☺
d) Most sufferers do not seek help.
e) None of the given options are correct.

70. The Rapee Information Processing Model of the development of generalised anxiety disorder (GAD) suggests that individuals with GAD selectively attend to:

a) body sensations of impending panic.
b) memories of trauma.
c) stress neurochemicals.
d) threatening information.☺
e) negative social cues.

71. In agorophobia sufferers avoid being in situations where:

a) there is a need to relate easily to others.
b) a panic attack may occur and escape from the situation is difficult. ☺
c) others may see them.
d) they are far away from home.
e) None of the given options are correct.

72. With regards to GAD, the Intolerance of Uncertainty Model interacts with three other processes that maintain GAD symptoms. One of them is:

a) holding positive beliefs about worry as a coping strategy. ☺
b) holding negative beliefs about worry as a coping strategy.
c) having a high level of confidence in one's ability to solve problems.
d) experiencing vivid negative images.
e) having low self-esteem.

73. What changes to the diagnostic criteria for GAD were enacted in the DSM-5?

a) Removed the criterion that worry should be difficult to control.
b) No changes were made in the DSM-5. ☺
c) Excessive anxiety and worry must be present for three, rather than six, months.
d) Reduced the number of associated symptoms.
e) Included the presence of behavioural symptoms such as time spent planning for potential threat.

80. An example of a social threat for sufferers of GAD is:

a) worrying about being the victim of a terrorist attack.
b) worrying about being involved in a car accident.
c) worrying about not being liked by others.☺
d) worrying about developing cancer.
e) None of these is an example of a social threat.

81. Which of the following is not one of the new approaches for helping people with GAD?

a) interpersonal psychotherapy (IPT)
b) mindfulness meditation approaches
c) addressing meta-worries
d) addressing problems coping with emotions
eye movement desensitisation retraining (EMDR) ☺

82. In Foa's 1991 randomised controlled trial of treatments for posttraumatic stress disorder, the treatment with the best long-term outcome was:

a) stress management.
b) imaginal exposure.
c) hypnotherapy.
d) supportive counselling.
e) prolonged exposure.☺

83. Development of a panic disorder requires:

a) a specific psychological vulnerability.
b) a generalised psychological vulnerability.
c) a generalised biological vulnerability.
d) All of these options are correct.☺

84. In vicarious acquisition, fear is acquired by:

a) classical conditioning.
b) verbal transmission of fear-related information.
c) observing another person responding with fear to a threat.☺
d) All of the given options are correct.
e) None of the given options are correct.

85. Which of the following is a change to PTSD for the DSM-5?

a) The individual's subjective response to the traumatic event is deleted.
b) Avoidance is redefined as active avoidance of helplessness or horror.
c) A new cluster is added involving negative alterations in cognitions and mood.
d) All of the given options are correct. ☺
e) None of the given options are correct.

Downloaded by moin khan (moinamb99@gmail.com)

Chapter 3 mood disorders

86. What is the new disorders listed in the DSM V in the chapter entitled 'depressive disorders'

Disruptive Mood Dysregulation Disorder (NEW)– sever persistent irritability and outbursts of anger that are out of proportion to the situation (more common in US than Aust)

87. What is anhedonia?

Anhedonia is the inability to experience pleasure from activities that were previously pleasurable

88. How are depression scales, such as the Beck Depression Inventory or the depression, anxiety and stress scale (DASS) used?

Depression inventories are not used in depression diagnosis, which is based on clinical interview. However, depression scales help assessing which symptoms are present, their severity and changes that occur during treatment.

89. How long does a depressive episode last?

A depressive episode usually last at least two weeks, usually 4-9 months, but has a median of 5. 10% of episodes of depression last two years without remission. There is a 90% chance the individual will remit but 85% they will experience is again with single episodes being is rare. Around four episodes in a life time is typical for major depressive disorder. While dysthymic individuals never have depressive symptoms severe enough to reach the threshold of 'major depressive order' however in a two year period there would not be any longer than a two month period when the person feels euthymic (normal mood)

90. What is different in the DSM V relating to bereavement and major depressive disorder?

Previously a state of bereavement excluded you from diagnosis of MDD but DSM V removes this but states that to avoid misdiagnosis of people during the adaptive adjusting period it is important to distinguish not-pathological grief (thoughts of the deceased) and major depression (such as self-critical thoughts). The bereavement exclusion clause was removed so that the 10-15% of mourners of suffer severe and crippling reactions can be treated. Critics are concerned that this will pathologies and medicalise a normal reaction to loss.

91. Describe the three mood states relating to depression

Euphoria – elevated mood
Euthymia – normal mood
Dysthymia – depressed mood

92. What is dysthymic disorder

Dysthymic disorder has been renamed "persistent depressive disorder", it is less severe but more chronic than MDD. It presents as low mood and two other adjunct symptoms (e.g. insomnia, poor self-esteem or low energy) Double depression is the experience of comorbid MDD and dysthymic disorder, therefore moving between states of major depression and dysthymia. Often individuals may view the dysthymic period as normal mood and may therefore not experience euthymia. Double depression is associated with;

- Severe psychopathology
- Problematic future course
- Very high rates of relapse

93. Why is it important to distinguish between unipolar and bipolar depression?

Unipolar depression may be treated with antidepressant medication which if given to a sufferer of bipolar may lead to a manic episode. Sufferers of bipolar disorder benefit from lithium (Australian John Cade 1942) which is a mood stabiliser. Also there is a 50% comorbity rate between biopolar and anxiety and antidepressant drugs can trigger manic prescribed for anxiety may also trigger manic episode.

This document is available on studocu

Downloaded by moin khan (moinamb99@gmail.com)

Aetiology of Unipolar Depression

Biological factors:

Genetic – 2-3 times more likely with family history

Epigenetic – interaction of genes and stressful life experiences

Biochemical – monoamine neurotransmitters in the limbic system, less related to reduced availability and more to do with receptor numbers and sensitivity

Neuroendocrine – hyperactivity in the HPA axis

Structural or functional changes in prefrontal cortex, hippocampus, anterior cingulate cortex and the amygdala

Environmental factors:

Stressful life events – (acute or chronic) involving loss or failure

Growing up in hostile violent or disruptive environment

Social Factors

Interpersonal difficulties – expressed emotion (EE) –family relationships involving high levels of criticism, hostility and over involvement

Symptoms of depression lead to deterioration in social functioning which perpetuates depression

Psychological factors:

Psychoanalytic theory – depression is a form of pathological grief. Involves disrupted bonding experiences in childhood

Behavioural theories –

- benefits derived from depressed behaviour (sympathy, avoid unpleasant tasks, defer responsibility)
- stressful experiences reduce the opportunity for positive reinforcement experiences (used to like movie but now unemployed and can't afford it)
- Learned helplessness – uncontrollable negative life experiences leads to feelings of helplessness

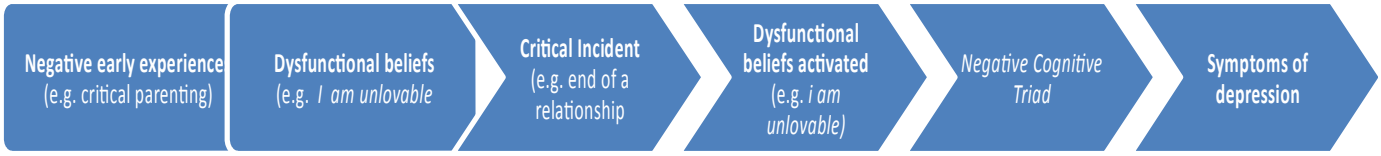
Cognitive theories –

- Attributional style – depressive attributional style is internal ('my fault'), global (applies to everything) and stable (unchanging)
- Beck – core belief – childhood negative experiences lead to dysfunctional core beliefs (I am unlovable)
- Cognitive triad – depressed individuals have negative views of themselves, the world and the future

Downloaded by moin khan (moinamb99@gmail.com)

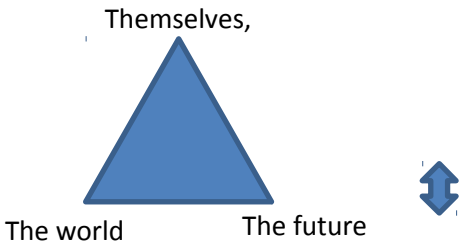
94. Describe Beck cognitive model of depressive episodes

95.


Negative early experience (e.g. critical parenting)
Dysfunctional beliefs (e.g. I am unlovable
Critical Incident (e.g. end of a relationship
Dysfunctional beliefs activated (e.g. i am unlovable)
Negative Cognitive Triad
Symptoms of depression

96. What is Beck's cognitive triad

Cognitive triad – depressed individuals have negative views of:



97. Describe the continuum of normal to abnormal relating to depression

It is normal to experience changes in mood, such as sadness or happiness, and mood exists on a continuum from normal to abnormal but the factors that determine whether a mood state is disordered are:

Distress – clinically significant distress
Dysfunction – functional impact from changes in: appetite, energy, concentration and decision making
Difference/distance – gross deviations, disturbances in mood state with longer than normal duration – deviate from culture or own personal values and that of your peer group

Depression is a normal part of human experience, an appropriate response to sad or difficult experiences, it is when this low mood is severe or persistent that treatment may become necessary.

98. Why is it important to distinguish between euthymic and manic experiences?

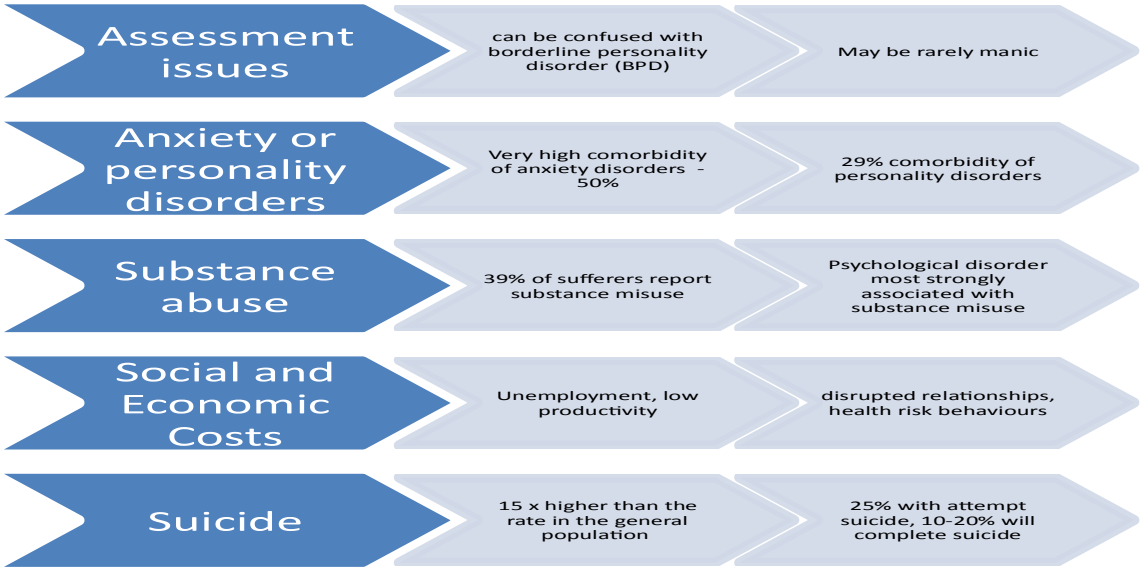
A sufferer of unipolar depression may describe a time when they felt wonderfully happy and describe this euthymic experience as "manic", however this is more of an indication that dysthymia has become the "new normal" for them and ordinary happy (euthymia) experiences are less common for them. As treatments for unipolar and bipolar differ it is important to make the distinction between mood states.

99. What are the symptoms of bipolar disorder?

Mood	Elevated, irratibility, hostility, feelings of exhilaration
Energy	little sleep, little fatigue, increased activity
Sexuality	Increased or decreased, may be inappropriate
Speech	Distruptions: 'pressured" or incoherent speech; "clang' associations ('vacancies, vagrancies and bacon seeds")
Thought patterns	distractability, creative thinking, flight of ideas, disorientation, disjointed thinking, racing thoughts
Judgement	Impaired: lack of insight, inappropriate humour and behaviours; impulsivity, financial extravagence, grandiose thinking
Perceptions	Inflated self-esteem, hallucinations, delusions, paranoia, increase religious activities

This document is available on studocu
Downloaded by moin khan (moinamb99@gmail.com)

100. What are the problems associated with bipolar disorder?


Assessment issues
can be confused with borderline personality disorder (BPD)
May be rarely manic
Anxiety or personality disorders
Very high comorbidity of anxiety disorders - 50%
29% comorbidity of personality disorders
Substance abuse
39% of sufferers report substance misuse
Psychological disorder most strongly associated with substance misuse
Social and Economic Costs
Unemployment, low productivity
disrupted relationships, health risk behaviours
Suicide
15 x higher than the rate in the general population
25% with attempt suicide, 10-20% will complete suicide

101. Describe the diathesis-stress model as it related to the aetiology of bipolar disorder

Chapter 3 summary

Unipolar depression

Mainly major depressive disorder and dysthymia
Periods of depressed mood and/or a loss of interest in activities, together with cognitive and physical symptoms
Women twice as likely as men to experience
Aetiology and treatment of depressive disorders include biological, environmental and psychological factors and their interaction

Biopolar depression

Occurrence of manic or hypomanic episodes, characterised by abnormally elevated or irritable mood with a range of physical, cognitive, and subsequent behavioural symptoms
Aetiology and Treatment: biological with psychological

Downloaded by moin khan (moinamb99@gmail.com)

Major Depressive Disorder (MDD)

Prevalence	Age of onset	Gender difference	Mortality
Around 3 % of males and 5% of females	The age of onset (median 30years of age) seen to be decreasing. Teenagers, girls more so than boys have increases in depressive symptoms that may relate to hormonal and social changes	Females 1.66 times more likely	Suicide around 2300 years in Australia 3.5% of MDD sufferers

DSM-5: Criteria

involves one or more major depressive episodes, with anhedonia of at least 2 weeks duration including significant distress and dysfunction (socially defined), must include 4 of:

Physical symptoms
- - weight loss/appetite loss,
- - insomnia/hypersomnia,
- - loss of energy/fatigue every day,
- - motor restlessness psychomotor agitation/retardation (catatonia),

Cognitive symptoms
- diminished concentration/indecisiveness,
- feeling of worthlessness/inappropriate guilt,
- thoughts of death/suicidal ideation/attempt

exclusions
- must never have a manic/hypo manic
- not attributable to drugs or medical conditions

DSM V attempts to deal with heterogeneity (diversity) in the presentation of major depression with the inclusion of specifiers, which are extensions to the diagnosis that further clarifies the course, severity or special features of the disorder, including:
- 'with melancholic features' – profound inability to experience pleasure, worse mood in the morning, and psychomotor retardation or agitation, with anorexia (i.e. loss of appetite) or weight loss and excessive guilt
- 'with catatonic features' – movement disturbance on a spectrum from immobility to purposeless activity
- 'with peripartum onset' (so not postnatal depression a separate condition instead major depressive disorder with peripartum onset)
- 'with seasonal pattern' – i.e. worse in winter
- 'with mixed features' – might include some elevated mood
- 'with anxious distress' – 50% of people with major depressive disorder also experience anxiety

Whilst DSM V attempts to deal with heterogeneity (diversity) in the presentation of major depression with the inclusion of specifiers, it fails to consider causal factors that may influence treatment options. It is suggested that classification based on psychotic, melancholic and non-melancholic would be of benefit as psychotic and melancholic are biologically based and respond better to medication, non-melancholic depression responds better to psychological approaches.

Progression 50% of people recover in the first 6 months with treatment, while 10% have a chronic course, and most relapse within 5years. A worse prognosis is associated with continuing depressive symptoms, previous history, family history, early onset, ongoing life stressors, and severe unipolar cases have a 90% probability of remission within 5 years.

Comorbidity

- Double depression is the experience of comorbid MDD and dysthymic disorder, is associated with;
  - Severe psychopathology
  - Problematic future course
  - Very high rates of relapse
- Anxiety Disorders – higher suicide risk and longer period of depression

Dysfunction

- Dysfunction/activities – difficulty performing occupational and social activities
- Physical health problems – including CVD (plus more likely to die following a heart attack than non-depressed individual, diabetes, and lower immunity..may result from health risk behaviours (remember the DEAL)

	Aetiology	Treatment
		Medical and psychological treatments (CBT & IPT) have been deemed equally effective, drugs are quicker but therapy more likely to prevent relapse however in the long term psychodynamic therapy and mindfulness is more effective in the long run.
Biological	**Predisposing Factors (vulnerabilities):** ➢ Genetic predisposition, sex differences (20-40%), neurotransmitters, 5HT, noradrenaline, HPA axis hyper responsiveness, inflammation, immune system Districted sleep cycles, metabolic syndrome?	Natural recovery - may improve over time without treatment but treatment can speed up recovery and reduce the risk of relapse Pharmacotherapy:caution – suicidal ideation – small effect size 0.32 efficacy rate

This document is available on studocu

Downloaded by moin khan (moinamb99@gmail.com)

	➢ Genetic – 2-3 times more likely with family history ➢ Epigenetic – interaction of genes and stressful life experiences ➢ Biochemical – monoamine neurotransmitters in the limbic system, less related to reduced availability and more to do with receptor numbers and sensitivity ➢ Neuroendocrine – hyperactivity in the HPA axis ➢ Structural or functional changes in prefrontal cortex, hippocampus, anterior cingulate cortex and the amygdala ➢ Australian researchers argue for classification by subtyping of psychotic & melancholic depression, which are theorised to be biologically based and non-melancholic which is driven by life events	• **Antidepressant medications** (TCA SSRI & MAOI)- -Best for biologically driven depression SSRI's have similar efficacy to older TCA's but with less side effects • **Antipsychotic medications** - Only for severe depressive disorders with psychosis – delusions and hallucinations • **ECT** - Severe MDD, mixed results – rTMS & vagus nerve stimulation • Bright light therapy - Seasonal affective disorder
Psycho	**Predisposing Factors (vulnerabilities)** ✓ locus of control, learned helplessness, cognitive style **Precipitating factors (Stressors):** ✓ Stressful life events, **Perpetuating factors (maintaining):** ➢ Low mood, anhedonia, suicidal ideation, helplessness **Theories** **Psychoanalytic theory –** depression is a form of pathological grief. Involves disrupted bonding experiences in childhood **Behavioural theories –** • benefits derived from depressed behaviour (sympathy, avoid unpleasant tasks, defer responsibility) • stressful experiences reduce the opportunity for positive reinforcement experiences (used to like movie but now unemployed and can't afford it) • Learned helplessness – uncontrollable negative life experiences leads to feelings of helplessness **Cognitive theories –** • Attributional style – depressive attributional style is internal ('my fault'), global (applies to everything) and stable (unchanging) • Beck – core belief – childhood negative experiences lead to dysfunctional core beliefs (I am unlovable) • Beck's Cognitive triad – depressed individuals have negative views of themselves, the world and the future	✓ Combined approaches (medical & psychological) - especially beneficial for sever chronic or recurrent depression ✓ CBT - Cognitive restructuring (identifying and challenging negative automatic thoughts (NATS) about self, world & future and behavioural techniques (such as planning pleasurable activities in a weekly schedule) (effect size range 0.39-0.82%)
Social	**Predisposing Factors (vulnerabilities):** ✓ Familial factors ✓ Growing up in hostile, violent or disruptive environments ✓ Expressed emotion- family relationships involving high levels of criticism, hostility and over involvement **Precipitating factors (stressors)** ✓ Stressful life events **Perpetuating factors:** ✓ Symptoms of depression lead to deterioration in social functioning which perpetuates depression ✓ Social withdrawal, interpersonal difficulties	✓ Interpersonal psychotherapy - Focuses on interpersonal problems that may be related to the onset and/or maintenance of the depressive episode – behavioural activation = getting in touch with old friends and other social activities which offset social withdrawal (purely behavioural)

Downloaded by moin khan (moinamb99@gmail.com)

	✓ Interpersonal factors (e.g. partnered versus single versus separated /widowed) ✓ Stress, social context, supports	

Bipolar Disorder (I & II)

Prevalence	Age of onset	Gender difference	Mortality
Over a 12 month period bipolar has a prevalence of 1-2% with 3-4% LP	25% of bipolar sufferers experience onset by age 17 with average age of 25 years.	bipolar I roughly equal between men and women. It is more common for women to be diagnosed with bipolar II,	

DSM-5: Criteria The difference between bipolar I and bipolar II is that bipolar II sufferers experience hypomanic episodes, subclinical manic episodes without psychotic features. Any manic episode ever makes it bipolar I. However, depression need not be experienced for diagnosis of bipolar I, though it may be present.

Mania = Elevated, expansive or irritable mood, with increased goal directed activity or energy plus three of:

- Pressure of speech
- Flight of ideas
- Distractibility
- Inflated self esteem
- Grandiosity
- Sleep disturbance
- Risk taking

Cyclothymia = is a condition where people present with subclinical hypomanic or depressive symptoms and are rarely without symptoms over a two year period (up or down but rarely 'normal'). 1 in 3 go on to develop bipolar.

Progression 40% relapse within a year, 60% within 2 years & 73% over 5 years

Comorbidity	Dysfunction
• Rule rather than the exception • Medical comorbidities = Diabetes, CVD, migraines • Psychological comorbidities = 95% suffer 3 or more conditions (anxiety, substance use, eating disorders, personality disorders)	Mania (7 weeks av), hypermania,(3 weeks av) depression (av 15 weeks)(not necessarily) episodes do not include hallucinations or delusions and the sufferer may present as charming, witty, the life of the party hospitalisation wouldn't be required. CARE: often misdiagnosed as schizophrenia, unipolar, borderline personality disorder

	Aetiology	Treatment
Bio	**Predisposing Factors (vulnerabilities):** ➢ There is a 6-9% lifetime risk in family member of bipolar sufferers compared to 1% in the general population. MZ twins 70% concordance ➢ Polygenic factors – epigenetics	➢ Mood stabilising medication (lithium) is very important in the treatment of bipolar disorder.25-50% of people fully protected – side effective (TD). Poor medication adherence ➢ ECT has been found to be helpful of mania, helping up to 80% of acute patients
Psycho	**Predisposing Factors (vulnerabilities)** ✓ Temperament – perfectionism, ✓ Cognitive disturbance – thoughts, beliefs, attitudes to illness **Precipitating factors (Stressors):** ✓ Stressful life event **Perpetuating factors (maintaining):** ✓ Poor coping strategies, defensive responsive style	➢ CBT - including psychoeducation, goal setting, challenging dysfunctional beliefs, structure and routine and self-monitoring (mood maintenance and moderating risky behaviours) ➢ Psychodynamic thought – mania as disruptive 'inner pressure' or positive 'infinite power". There is a frequent expectation and hypersensitivity to rejection – a defensive mechanism. Commonly bipolar sufferers will be in denial = "fix the depression keep the mania"
Social	✓ Stressful life events ✓ **Diathesis stress model** – which is the interaction between the underlying vulnerability and the stressful life event	➢ Interpersonal and social rhythm therapy (build a routine and helps to navigate social routines more effectively. – with CBT found that less manic episodes ➢ Family intervention

This document is available on studocu

Downloaded by moin khan (moinamb99@gmail.com)

	✓ Goal dysregulation model – excessive goal engagement ✓ need for social acceptance	➢ relapse prevention

Downloaded by moin khan (moinamb99@gmail.com)

102. What percentage of people with a major depressive disorder also experience significant anxiety symptoms?

a. 5 per cent
b. 10 per cent
c. 25 per cent
d. 50 per cent ☺
e. 70 per cent

103. When treating people with bipolar disorder, offering psychoeducation sessions as well as medication is likely to:

a. trigger a mood shift to the opposite pole.
b. be ineffective due to their current symptoms.
c. increase the rate of relapse.
d. reduce the rate of relapse.☺
e. decrease compliance with medication.

104. A major depressive disorder is characterised by the following symptoms except:

a. grandiosity. ☺
b. weight loss.
c. sleep disturbance.
d. psychomotor agitation or retardation.
e. excessive guilt feelings.

105. With regards to bipolar I disorder:

a. It is more common in women.
b. It is more common in men.
c. It is equally common in men and women. ☺
d. It is only found in women.
e. The gender ratio is unknown.

106. Beck's definition of the 'negative cognitive triad' does not include a negative view of the:

a. past. ☺
b. future.
c. self.
d. world.
e. None of the given options are included in the triad.

107. An Australian research team has argued for a subtyping model with three broad classes of depressive disorders: psychotic, melancholic and non-melancholic. Which of the following are theorised to be primarily biologically based?

a. melancholic and non-melancholic depression
b. psychotic and melancholic depression☺
c. psychotic and non-melancholic depression
d. psychotic and non-psychotic
e. melancholic, non-melancholic and psychotic

115. After first episode of depression, most people:

a. seek professional treatment as soon as possible.
b. recover within one week.
c. make a suicide attempt.
d. never have another depressive episode (relapse).
e. have another depressive episode (relapse) within 5 years.☺

116. For a diagnosis of bipolar disorder, a person must have experienced at least one:

a. major depressive episode.
b. psychotic episode.
c. dysthymic episode.
d. anxiety episode.
e. manic or hypomanic episode.☺

117. Which of the following is not typically associated with a manic episode?

a. inflated or expansive mood
b. inflated self esteem
c. high trait anxiety ☺
d. risk taking
e. grandiosity

118. On average, an individual with bipolar disorder is likely to experience:

a. more time being manic or hypomanic than being depressed.
b. more time being depressed than being manic or hypomanic.☺
c. equal time being depressed and being manic or hypomanic.
d. only time being manic, no time being depressed.
e. None of the given options is correct—none of these patterns is more common than the others.

119. Aaron Beck's cognitive theory of depression suggests that in individuals with depression:

a. dysfunctional negative cognitions result in depressive symptoms.
b. depressive symptoms lead to negative cognitions.
c. dysfunctional negative cognitions result in depressive symptoms and depressive symptoms lead to negative cognitions.☺
d. neither do dysfunctional negative cognitions result in depressive symptoms nor do depressive symptoms lead to negative cognitions.
e. depressive symptoms result in negative cognitions.

120. Neuroendocrine (hormonal) theories of depression suggest that one cause of depression may be:

a. an underactive HPA axis producing too few stress hormones.
b. an overactive HPA axis producing too many stress hormones.☺
c. reduced availability of monoamine neurotransmitters.
d. structural or functional abnormalities of brain structures.
e. decreased availability of dopamine within the brain.

121. Relapse prevention treatment for bipolar

This document is available on studocu

Downloaded by moin khan (moinamb99@gmail.com)

108. The association between depression and physical/medical illness is not explained by:

a. better immune functioning in people with depression. x
b. ongoing stressors of dealing with a medical illness.
c. physical/hormonal changes due to medical illness.
d. unhealthy lifestyle choices by people with depression.
e. a virus common among people with depression. x

109. Unipolar depression is different from normal unhappiness in that:

a. it is precipitated by psychosocial stressors.
b. it is precipitated by negative life events.
c. depressed mood is more intense and/or lasts longer.☺
d. it involves manic episodes.
e. it is accompanied by physical symptoms.

110. A major depressive disorder with melancholy has all the following features except:

a. inability to experience pleasure.
b. early morning wakening.
c. excessive guilt.
d. weight loss.
e. catatonic symptoms. ☺

111. Within 6 months following treatment, approximately what percentage of people with major depression will experience recovery?

a. 5 per cent
b. 15 per cent
c. 35 per cent
d. 50 per cent☺
e. 80 per cent

112. Which of the following are considered protective factors that reduce an individual's chance of depression?

a. good interpersonal skills and positive relationships with others
b. high levels of family cohesion
c. a temperament characterised by optimism and low anxiety
d. an openness to the possibility of exploring new experiences
e. All of the given options are correct.☺

113. The suicide rate in Australia has _____ since the late 1990s.

a. declined ☺
b. increased
c. stayed the same
d. doubled
e. None of the given options is correct.

disorder includes all of the following except:

a. psychoeducation.
b. symptom monitoring.
c. challenging unhelpful cognitions.
d. taking medication only when feeling unwell.☺
e. being aware of early warning signs of relapse.

122. The family communication style known as high expressed emotion (EE) entails high levels of all of the following except:

a. support. ☺
b. criticism.
c. hostility.
d. over-involvement.
e. All of the given options are part of high EE.

123. Postnatal depression is a:

a. brief period of depression after childbirth, occurring in 70 per cent of women.
b. less-common but serious disorder after childbirth, which may include symptoms of psychosis.☺
c. seasonal affective disorder.
d. mild long-term condition, involving low mood, which does not meet criteria for depression.
e. type of depression that does not respond to medication.

124. Among adolescents in developed countries, depressive disorders:

a. are more common in boys than in girls.
b. are more common in girls than in boys.☺
c. are equally common in boys and girls.
d. are more common in urban than in rural young people.
e. have been decreasing in prevalence in the last 10 to 15 years.

125. Which of the following does current research evidence not support as an effective treatment for depression?

a. interpersonal psychotherapy
b. medication
c. cognitive behaviour therapy
d. psychodynamic therapy ☺
e. All of the given options are effective treatments for depression.

126. The Goal Dysregulation Model suggests that mania is the result of:

a. cognitive distortions.
b. mood swings.
c. stress.
d. psychomotor retardation.
e. excessive goal engagement.☺

Downloaded by moin khan (moinamb99@gmail.com)

114. A new mood disorder—mixed anxiety depressive disorder—has been incorporated into the DSM-5 for all of the following reasons except: a. the strong comorbidity between depression and anxiety problems. b. the increased risk of suicide associated with mixed anxiety and depression. c. the longer length of the depressive episode when depression is mixed with anxiety. d. to enable clinicians to identify people at risk of a full-blown major depressive disorder or a significant anxiety disorder. e. All of the given options are correct. ☺	

Chapter 4 Psychosis

127. What are the positive symptoms of psychosis?

The positive symptoms of psychosis are called so because they involve the 'addition of disturbances':

- Delusions-
- Hallucinations – perceptual disturbances
- Disorganisation in thought and behaviour
- Motor disturbances

128. What are the negative symptoms of psychosis?

The negative symptoms of psychosis are so called because they involve deficits in cognitive processes:

- Avolition – loss of drive or motivation
- Affect flattening – dampening of emotional expression
- Alogia – lack of unprompted speech "poverty of speech"

129. What is the definition of a hallucination and what are example of hallucinations?

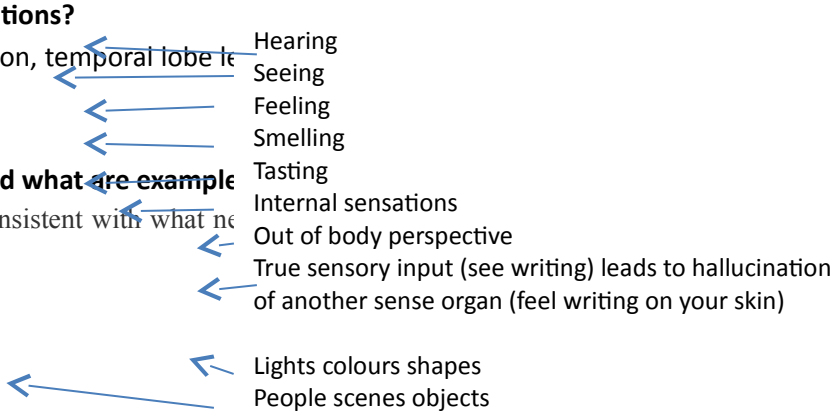
Hallucinations are perception-like experiences with the clarity and impact of a true perception but without external stimulation of the relevant sensory organ. Hallucinations can be:

130. What other conditions cause hallucinations?

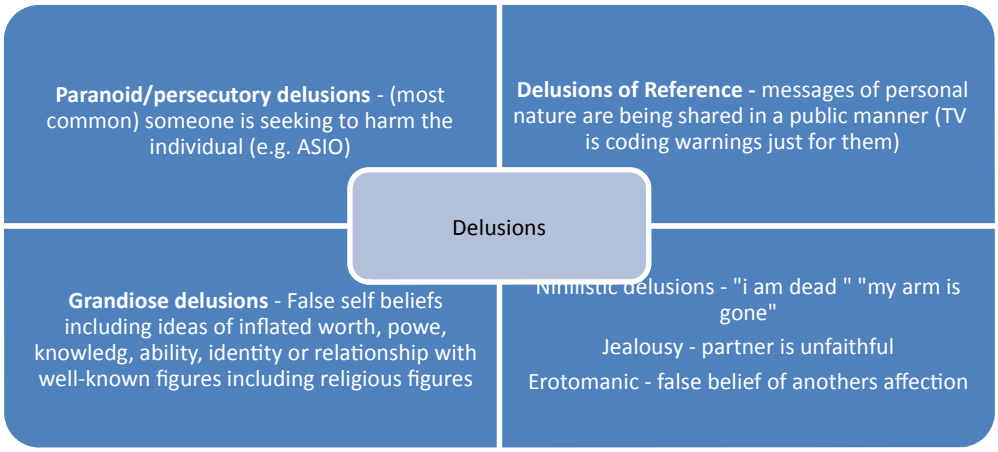
Hallucinations can also be involved in intoxication, temporal lobe le
injury and bipolar disorder.

131. What is the definition of a delusion and what are example

A delusion is a strongly held belief that is not consistent with what ne
proof to the contrary. Examples include:



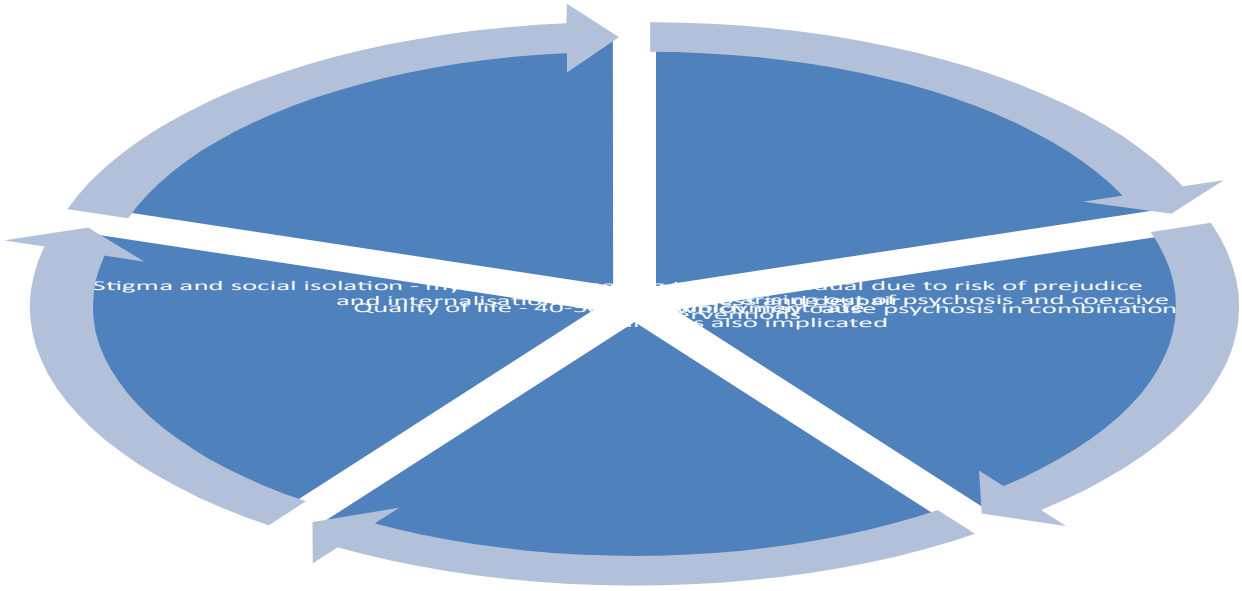
This document is available on studocu
Downloaded by moin khan (moinamb99@gmail.com)


Paranoid/persecutory delusions - (most common) someone is seeking to harm the individual (e.g. ASIO)
Delusions of Reference - messages of personal nature are being shared in a public manner (TV is coding warnings just for them)
Delusions
Grandiose delusions - False self beliefs including ideas of inflated worth, powe, knowledg, ability, identity or relationship with well-known figures including religious figures
Nihilistic delusions - "i am dead " "my arm is gone"
Jealousy - partner is unfaithful
Erotomanic - false belief of anothers affection

132. What is the difference between a primary and secondary delusion?

A primary delusions appears '*de novo*' or out of the blue and are more uncommon while secondary delusions appear out of a change in mood or arise out of previous idea or experience such as a hallucination.

133. What are five features associated with schizophrenia?



134. What have been some concerns raised by researchers regarding the diagnosis of schizophrenia?

It is argued that depressive, bipolar and psychotic disorders as distinct domains do not fit with clinical reality and a dimensional approach should be taken. Also the stigma of the schizophrenic label should be removed or action taken to reduce fear and ignorance in the community.

135. Why is early detection of psychosis an important aim?

Early detection of psychosis is important because young people often go untreated for a long time, in the 1990's usually around a year. In addition to this prolonged period of suffering the longer the period of delay before treatment commences, the 'duration of untreated psychosis' or DUP, the longer it takes to respond to treatment once it commences.

136. What is the course of psychotic disorders?

Following an acute episode of psychosis acute symptoms generally subside within the early months, however 40% of those on medical and 65% who stop taking medication relapse within 1 year.

i. Premorbid phase – prior to displaying mental health symptoms (inc. viral infection in utero, behavioural problems
ii. Prodromal phase – subtle potential indicative signs – CBT to prevent/delay onset
iii. Acute phase – positive and negative psychotic symptoms 1. Inpatient or outpatient psychological support and psychoeducation, 2. Drug treatment with antipsychotics,

Downloaded by moin khan (moinamb99@gmail.com)

iv. Early recovery phase –when symptoms improve deal with anxiety (inc. PTSD & social phobia) and depression (medication & CBT), better recovery for those who make an active effort to understand the condition

v. Late recovery phase – reintegration into society, avoid recurrence (CBT, medication & manage expressed emotion family situations)

vi. Enduring psychosis phase –persists despite treatment – involves increased problems with attention, memory and executive function, about 50% will eventually show significant improvement

137. Negative symptoms in psychosis are easily confused with:
✓ laziness.

138. The strongest research support for the existence of a genetic vulnerability to schizophrenia comes from:
✓ adoption studies.

139. With 2 parents diagnosed with schizophrenia may have a greater risk of developing the disorder. This suggests:
✓ the disorder is genetically determined.

140. The hallucinations reported by people with schizophrenia are most often:
✓ auditory (hearing) and these hallucinations are also common in the general population

141. For people with long-term psychosis and persistent positive symptoms, provision of cognitive behaviour therapy (CBT) as well as medication is likely to:
✓ reduce psychotic symptoms during CBT treatment and have long-term benefits after CBT treatment ceases.

142. The risk of further episodes of psychosis within the first 5 years after treatment is not associated with:
a) discontinuation of medication.
b) alogia. ☺
c) poor premorbid history.
d) high expressed emotion in interpersonal relationships.
e) substance abuse.

143. Thought disorder is:
✓ a disturbance in the coherence and sequencing of thought.

144. Which of the following best describes the prodromal phase of a psychotic disorder?
✓ the gradual period of deterioration in mental status, before the onset of acute symptoms of psychosis

145. In psychosis, negative symptoms include:
✓ lack of drive, motivation, emotional expression and spontaneous speech.

146. A neologism is:
✓ a false word. – a newly coined word or expression

147. Formal thought disorder includes the following except:
a) lack of coherence of thought.
b) circumstantiality. – indirect and long winded
~~c) catalepsy. (Rigid body)~~☺
d) derailment. – slipping off one idea onto another (related to tangentiality – oblique irrelevant responses)

150. Use of cannabis by people with psychosis:
✓ increases their rate of relapse.

151. Which of the following is not true of catatonia?
✓ It is less responsive to treatment for schizophrenia.

152. During the early recovery phase of psychosis:
a) problems with depression and social anxiety may emerge.
b) patients express that they were traumatised by their experience of psychosis.
c) patients may either respond defensively to the past experience of psychosis or try to make sense of their experiences.
d) family members may remain distressed and worried.
e) All of the given options are correct.☺

153. Eugene Bleuler invented the term 'schizophrenia' referring to:
✓ the loosening of connections between thought structures.

154. During treatment of an acute episode of psychosis, medication is likely to:
✓ eliminate positive symptoms.

155. The Zubin and Spring stress vulnerability model of causes of psychosis suggests that vulnerability to psychotic illness:
✓ can include both psychosocial and biological factors.

156. Which of the following is a change for psychotic disorders in the DSM-5?
✓ the removal of all of the subtypes (replaced with dimensional approach – mild mod etc)

157. Morrison (2001) proposed a cognitive model for the development of positive symptoms of psychosis. The key component is:
✓ how intrusions into consciousness are interpreted.

158. A serious side effect of neuroleptic medication is:
✓ tardive dyskinesia.

159. Psychotic illnesses are more prevalent:
a) in developing nations than in developed nations. (Developed ++)
b) in people born in rural settings rather than in urban settings. (Urban ++)
c) in migrants than in non-migrants. ☺
d) All of the given options are correct.

This document is available on studocu
Downloaded by moin khan (moinamb99@gmail.com)

e) echolalia. – mimicking speech

148. Which is not a typical symptom of catatonia? (Catatonia is less responsive suggesting a neurobio basis!!)

a) catalepsy – rigid body
b) echolalia – mimic speech
c) echopraxia – mimic movement
d) anhedonia - negative symptom loss of motivation☺
e) waxy flexibility – maintains posture like a puppet if moved into position stays there

149. An individual with schizophrenia who believes that the television newsreader is sending coded messages to them is demonstrating what type of delusion?

✓ delusion of reference

e) None of the given options are correct.

160. Which of these is not a first rank symptom of schizophrenia, according to Schneider's classification system?

a) bizarre delusions including passivity phenomena
b) elevated mood ☺
c) hearing voices arguing
d) hearing voices commenting on the individual's actions

161. Psychotic delusions are usually categorised in terms of their:

✓ content and plausibility/bizarreness**.**

Downloaded by moin khan (moinamb99@gmail.com)

Schizophrenia

Prevalence	Age of onset	Gender difference	Mortality
Psychotic disorders are relatively rare, around 1% of the population, appear at a higher rate in migrants, in developed nations and in people born and raised in urban areas.	While the prodromal phase (the deterioration in mental state and function) may be nothing or years, the peak period of onset of schizophrenia is during late adolescence and early adulthood.	are more common in men than women,	5-10% suicide rate

DSM-5: Criteria Six months of continuously presents signs of schizophrenia (such as gradual deterioration) but must include a least one month of psychotic symptoms including two or more of the following:

- Positive symptoms: delusions, hallucinations, disorganised speech (such a clang speech) grossly disorganised thoughts & behaviour (i.e. walking back and forward on the spot) or catatonic behaviour (motor abnormalities)
- Negative symptoms ("loss of….)– avolition, affect flattening & alogia

Progression Following an acute episode of psychosis acute symptoms generally subside within the early months, however 40% of those on medical and 65% who stop taking medication relapse within 1 year. Course – premorbid (prior), prodromal (early signs), acute phase (positive & negative symptoms,) early recovery, late recovery and enduring psychosis. 80-90% relapse within 5 years. ½ of patients significantly improve

Comorbidity	Dysfunction
➢ Often with comorbid substance use disorders, depression and anxiety – PTSD as a result of involuntary treatment	➢ Positive and negative symptoms ➢ Stigma and social isolation ➢ Quality of life – 40-50% unemployment

	Aetiology	Treatment
Biological	**Predisposing Factors (vulnerabilities):** ➢ With heritability rate of around 80% the genetic link is beyond question and it would appear most unlikely to develop psychosis without this genetic inheritance. ➢ Twin studies however show that identical twins have 50% concordance rates for schizophrenia; therefore the environment also has a role to play. ➢ The dopamine hypothesis for psychosis claims that increased dopamine increases schizophrenic-like behaviour. This finding is based on studies of use of dopamine modifiers (but too simplistic). It is possible that oversensitive dopamine receptors may play a role. ➢ Psychosis may occur as a result of neurodevelopmental damage (eg during pregnancy), due to early trauma or drug use ➢ It appears that individuals with psychosis display enlarged ventricles and reduced tissue volume (loss of brain tissue), including the prefrontal cortex: loss of tissue for those with negative symptoms. Hippocampal abnormalities are also evident which are not unique to schizophrenia.	➢ Antipsychotic medications (neuroleptic drugs) can be used at the lowest effective dose to act on the active symptoms of psychosis. In use since the 1950's these drugs reduce or eliminate the positive symptoms. However side effects such as weight gain and more uncommonly (10% of those treated for over 12 months) tardive dyskinesia = neurological disorder characterised by involuntary movements of the tongue, face mouth or jaw and Parkinson-like effects may occur and compliance with medication is often a problem. The focus of treatment however is changing from suppressing positive symptoms to improving quality of life and reintegration in keeping with recovery-oriented models. ➢ Historically sufferers of psychosis have been heavily medicalised and medicated. However by using a **recovery-orientated model from a biopsychosocial perspective comprehensive treatment plans focus on staying well after psychosis and achieving a satisfying quality of life.**

This document is available on studocu

Downloaded by moin khan (moinamb99@gmail.com)

Psychological	**Predisposing Factors (vulnerabilities)** ➢ The Zubin and Spring stress vulnerability model of causes of psychosis suggests that vulnerability to psychotic illness: can include both psychosocial and biological factors. **Precipitating factors (Stressors):** ➢ Stressful life experiences **Perpetuating factors (maintaining):** ➢ Morrison (2001) proposed a cognitive model for the development of positive symptoms of psychosis. The key component is how intrusions into consciousness are interpreted.	➢ Comprehensive approach = CBT + Medication reduce psychotic symptoms during CBT treatment and have long-term benefits after CBT treatment ceases. ➢ Prevention - evidence to suggest that psychosis may be prevented which early intervention. It has been found that CBT can be effective in individuals who are at high risk and displaying prodromal symptomology, with only 6% of those given CBT going on to develop psychosis compared to 22% of those simply monitored. ➢ Also by reducing triggering factors such as psychosocial stressors and exposure to illicit substance the likelihood and psychosis or relapse would be reduced ➢ CBT – combined with medication in early recovery phase – psycho education better recovery for those who make an active effort to understand the condition ➢ Late recovery phase - avoid recurrence – CBT in combination with medication
Social	**Predisposing Factors (vulnerabilities):** ➢ The diathesis –stress model can be applied to psychosis to explain the relationship between this genetic biological vulnerability and environmental factors such as environmental toxins (i.e. drugs particularly cannabis, cocaine, LSD or amphetamines) and/or stressful life circumstances interplay to increase likelihood of disease progression and act as triggering factors. The study of these gene-environment interactions are known as epigenetics. ➢ Drugs do not directly cause schizophrenia, but studies have shown drug misuse and stress such as childhood trauma, increases the risk of developing schizophrenia or a similar illness. **Precipitating factors (stressors)** ➢ stressful life circumstances may trigger symptoms of schizophrenia in people who are susceptible. ➢ abuse, migration and social exclusion increases risk **Perpetuating factors:** ➢ Family: show ineffective communication patterns "high expressed emotion" - criticism, hostility, emotional over-involvement = associated with relapse	➢ Late recovery phase – reintegration into society, manage fs family situations) ➢ Despite the improvements in treatment options there are significant gaps in access to psychosocial treatment and therefore much more to be done to improve the lives of those living with schizophrenia. An ethical appreciation and value for the persons lived experience and an understanding that your responses as a clinician can have serious implications for the experience of the individual is also required.

Downloaded by moin khan (moinamb99@gmail.com)

162. What are psychosomatic disorders?

Psychosomatic disorders are those which have identifiable physical symptoms which are caused at least in part by psychological factors together with physiological mechanisms. For example heart disease can be seen to have physiological mechanisms such as inflammation together with psychological factors such as acute or chronic stress. This is in contrast with somatic disorders where there is no diagnosable medical disease and/or the sufferer experiences abnormal reactions to the symptoms.

163. What was the major change in the DSM-5 related to somatic disorders?

In the DSM-5 Somatic symptom disorder and illness anxiety disorder replaced somatoform disorder to allow for the fact that it is difficult to determine whether a symptom results from an undiagnosed medical condition or from psychological mechanisms. The differentiation may be found in the number and persistence of symptoms, degree of preoccupation and intensity of illness worry as well as the forceful seeking of medical care.

164. Why are somatic and dissociative disorders grouped together? (What key shared phenomena?)

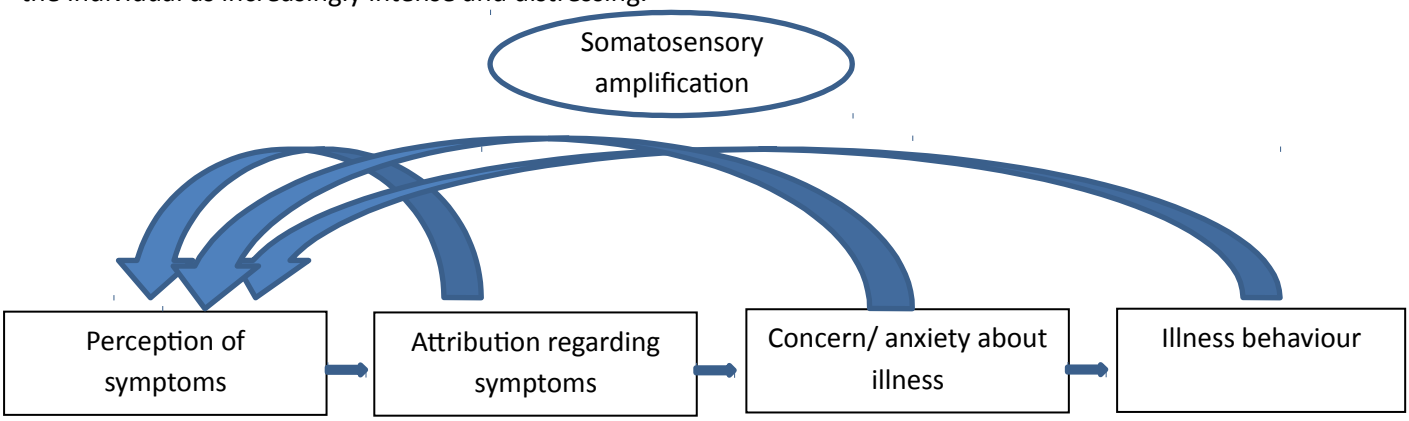
In both somatic and dissociative disorders there can be seen to be dissociation, a splitting off, occurring between mental awareness and another part of the normally integrated mental system. In somatic disorders the split off involves the somatic or motor system rather than higher mental functioning such as memory or identity Somatic symptom disorder and related condition involve somatic symptoms and excessive concern about them whilst dissociative disorders involve the disruption in the integration in once sense of identity.

165. What is la belle indifference?

La belle indifference is a common feature of conversion disorder involving a lack of concern regarding one's loss of bodily functions.

166. What is somatosensory amplification?

The cognitive behavioural model of somatisation process focus on individual experience and perception of physical symptoms, beliefs regarding the cause of the symptoms (attribution), associated concerns and anxiety and finally help seeking behaviour. It is proposed that these factors influence each other in a manner to lock the individual into a cycle of increasing somatosensory amplification, whereby somatic sensations are experienced by the individual as increasingly intense and distressing.



This document is available on studocu
Downloaded by moin khan (moinamb99@gmail.com)

Somatic Symptom and related disorders

Prevalence	Gender difference
Somatic symptoms disorder (SSD) 5-7**%. Illness anxiety disorder (IAD)**-1.3-10%	SSD higher in females than in males
Conversion disorder 5% of clinical patients. **Factitious disorder** 1% of patients in hospital settings	(IAD) equal in females and males

DSM-5: Criteria

SSD: One or more persistent (6 months +) distressing and debilitating somatic symptoms accompanied by abnormal thoughts feelings and behaviours (persistent & disproportionate thoughts, anxiety, time and energy devoted to symptoms (i.e. pain, gastrointestinal such as bloating, neurological such as paralysis or loss of consciousness

IAD: Illness preoccupation and anxiety for 6 months+ in the absence of marked somatic symptoms (i.e. cardiac neurosis or cancer phobia)

Conversion disorder:(functional neurological symptom disorder) Disturbance of one or more motor or sensory functions (paralysis, seizures, blindness, gait or swallowing) in absence of medical or mental disorder. Includes mass hysteria (many people all suffering symptoms). Acute (<6m) or persistent (>6m)

Factitious Disorder: Feigning illness with symptoms inaccurately reported or self-induced (Inc. Munchausen's and Munchausen's by proxy) deception without external incentive (i.e. not malingering for compensation or avoid military service)

Progression

Care is required as up to 30% of symptoms presented to general practitioners remain unexplained from a medical perspective and anxiety and depression are common in this group, with greater number of symptoms leading to higher likelihood of anxiety and depression.

Aetiology & Treatment

Before any intervention is adopted we must first: Minimise the number of treating clinicians, Unpack physiological and psychological causes of various symptoms, Identify and minimise reinforcers such as illness associated attention, Treat comorbid medical and psychological disorders impacting functioning

Bio	**Predisposing Factors (vulnerabilities) & Perpetuating factors (maintaining):** ➢ HPA axis dysregulation - reduced cortisol levels (hormonal vulnerability) ➢ After stopping exercise low cortisol leads to feeling of fatigue ➢ Damasio False body maps – neural representations that give rise to somatic symptoms ➢ Gate control theory – degree of pain experienced determined by how open or closed the pain gates are, greater pain more open, greater activity in other areas more likely to be closed, negative emotions can activate the gates positive emotion closes the gate – anxiety turns on pain)	Treat symptoms with and without medical causes ➢ Pain relief medications ➢ Relaxation ➢ Distraction ➢ Attention training ➢ Pharmacotherapies for anxiety or depression ➢ Coordination between health professionals
Psycho	**Predisposing Factors (vulnerabilities)** ➢ alexithymia= diminished capacity to consciously experience or describe emotions ➢ Greater sensitivity to sensation **Precipitating factors (Stressors):** ➢ Paying symptoms greater attention ➢ PTSD model – result of contained emotions, reflex actions or bodily sensations **Perpetuating factors (maintaining):** ➢ Somatosensory amplification: The cognitive behavioural model of somatisation process focus on individual experience and perception of physical symptoms, beliefs regarding the cause of the symptoms (attribution), associated concerns and anxiety and finally help seeking behaviour	Referral to psychologist ➢ Reattribution (from medical to psychological) ➢ Challenging thoughts ➢ Education (connection between psychological stress and physical illness) ➢ Self-monitoring (keeping diaries)
Social	**Predisposing Factors (vulnerabilities):**	➢ Graded activity, early return to work , assist with rapid

Downloaded by moin khan (moinamb99@gmail.com)

	Early childhood trauma	resolution of compensation claims ➢ Couple or family therapy

This document is available on studocu

Downloaded by moin khan (moinamb99@gmail.com)

167. Name and define five experiences that are considered pathological dissociation.

Amnesia: absense of memory for a specific and significant period of time (i.e. high school graduation) May include dissociative fugue (journey involving amnesia and new identity adoption)

Depersonalisation: change in the individuals sense of physical self (e.g. feeling like a detached observer/ body feels unreal)

Derealisation:change in the individuals sense of the world (e.g. as if in a dream/ surroundings feel unfamiliar)

Identity confusion: feeling of uncertainty or confusion regarding one's identity

Identity alteration: the most extreme form of dissociation where objective behaviours indicate that the individual has assumed alternative identities at different times

168. Discuss the challenges in conducting treatment outcome research with a problem such as dissociative identity disorder.

Both longitudinal and cross sectional studies show that active treatment leads to significant improvement for individuals with DID. However, DID is unlike to respond to treatment in the short term and therefore long term studies over several years would be required. As it would be unethical to assign a group of participants to a no-treatment control group over a long period, evidence from studies which do show reduction in levels of dissociation and related problems such as PTSD, depression, distress and suicidality, remains unclear whether the improvement was due to the therapy. However, it should be noted that sufferers of DID are unlikely to improve if not treated, coupled with potentially waiting around 12 years in the mental health system before being accurately diagnosed, therefore the lack of a control group become somewhat less of an issue.

169. What is the addition in the DSM-5 to the criteria used in diagnosing DID?

✓ Pathological possession is included.

170. Brief experiences of depersonalisation are:

✓ common in the general population.

171. People with somatic disorders have been found to have higher levels of:

✓ alexithymia= diminished capacity to consciously experience or describe emotions

172. Cognitive-behavioural models of the somatisation process centre on:

✓ the cycle of increasing somatosensory amplification.

173. Most individuals with dissociative identity disorders also meet criteria for:

✓ posttraumatic stress disorder (PTSD).

174. Explanations of the apparently increasing prevalence of dissociative disorders include which

184. Psychological intervention for chronic somatic symptoms:

✓ requires a strong therapeutic relationship.

185. The most common precipitants of depersonalisation include all of the following except:

a) amnesia. ☺
b) anxiety.
c) substance abuse.
d) stress.
e) depression.

186. In the DSM-5, somatic symptoms and related disorders comprise all of the following except:

a) conversion disorder.
b) illness anxiety disorder.
c) factitious disorder.
d) somatic symptom disorder.
e) somatoform disorder. ☺

187. According to the Iatrogenic Theory, dissociative identity disorder is the product of:

✓ therapy or the popular media.

Downloaded by moin khan (moinamb99@gmail.com)

of the following?

✓ More cases are being detected by new and valid assessment tools i.e. Dissociative experiences scale

175. Factors that help to identify somatic symptom disorder as a mental disorder rather than a medical condition include all of the following except:

a) the persistence and number of symptoms.
b) bodily preoccupation.
c) ~~presence of anxiety and depression~~. ☺
d) illness worry.
e) constant seeking of medical help.

176. A common feature of a conversion disorder is a lack of concern about the loss of bodily functioning. This is known as:

✓ la belle indifference.

177. The more physical symptoms an individual experiences the more likely it is that:

✓ they will be both depressed and anxious.

178. The disorder with the most overlap with dissociative identity disorder is:

✓ posttraumatic stress disorder.

179. The posttraumatic model of dissociative identity disorder argues that most individuals with this disorder show the following except:

a) a reported history of childhood trauma and abuse.
b) post traumatic stress disorder.
c) high trait anxiety. ☺
d) None of the given options are correct.
e) All of the given options are correct.

180. Somatic disorders and dissociative disorders both involve:

✓ dissociative processes.☺

181. According to the fantasy model of dissociative identity disorder:

✓ highly dissociative individuals are highly fantasy prone.

182. The main difference between somatic disorders and psychosomatic disorders is that:

✓ for psychosomatic disorders there is a physiological explanation linking the stress and the symptom.

188. The International Society for the Study of Trauma and Dissociation guidelines for the treatment of dissociative identity disorder emphasise all of the following treatment components except:

a) hypnosis. ☺
b) confronting traumatic memories.
c) establishment of a safe environment.
d) integration.
e) rehabilitation.

189. Pathological dissociation may involve all of the following except:

a) depersonalisation.
b) derealisation.
c) amnesia.
d) identity confusion.
e) excessive daydreaming. ☺

190. Dissociative disorders all involve which of the following?

✓ disconnection of normally integrated mental functions

191. Treatments for chronic somatic symptoms and related disorders include all of the following except:

a) relaxation.
b) exploring unconscious thoughts.
c) graded exposure. ☺
d) distraction.
e) challenging unhelpful thinking.

192. Brain activation associated with amnesia implicate:

✓ the prefrontal cortex (decreased activity in hippocampus – loss of declarative memory not non-declarative memory)

193. Which of the following is true of the finding that symptoms of anxiety and depression are common among people with medically unexplained physical symptoms?

a) It supports the theory that psychological distress is converted into somatic symptoms.
b) It challenges the theory that psychological distress is converted into somatic symptoms.
c) It confirms that the traditional physical model of illness is well-suited to managing these disorders.
d) It challenges that the traditional physical model of illness is well-suited to managing these disorders.☺
e) None of the given options is correct.

This document is available on studocu

Downloaded by moin khan (moinamb99@gmail.com)

183. What percentage of patients presenting to their general practitioners have symptoms that remain medically unexplained? ✓ greater than 20 per cent (close to 30%)	

Downloaded by moin khan (moinamb99@gmail.com)

Dissociative Disorder

Prevalence	Age of onset	Gender difference	Mortality
Brief depersonalisation 26-74% Depersonalisation/derealisation disorder (DDD) 0.8-2.4% Dissociative amnesia 1.8% (or 0% controversial) DID = 0.4-3.1%	Average 16 for DDD	DDD equal rates	

DSM-5: Criteria

Depersonalisation: change in the individuals sense of physical self (e.g. feeling like a detached observer/ body feels unreal)

Derealisation: change in the individuals sense of the world (e.g. as if in a dream/ surroundings feel unfamiliar)

Amnesia: absence of memory for a specific and significant period of time (i.e. high school graduation) May include dissociative fugue (journey involving amnesia and new identity adoption)

Identity confusion: feeling of uncertainty or confusion regarding one's identity

Identity alteration: the most extreme form of dissociation where objective behaviours indicate that the individual has assumed alternative identities at different times

Progression Sufferers of DID are unlikely to improve if not treated, coupled with potentially waiting around 12 years for an accurately diagnosis

Comorbidity	Dysfunction
• Vast majority have PTSD • Depression	➢ Distress and suicidality

	Aetiology	Treatment
Bio	**Predisposing Factors (vulnerabilities):** ➢ DID conflicting evidence on genetic basis ➢ DDD can be triggered by drug use	Pharmacotherapy = many in testing including SSRI's, naltrexone and epilepsy drugs but none considered a treatment of choice
Psycho	**Predisposing Factors (vulnerabilities)** **Precipitating factors (Stressors):** ➢ Depersonalisation = Stress, depression, anxiety & substance use **Perpetuating factors (maintaining):** The two opposing theories in term of the aetiology of DID, which has resulted in considerable controversy are: ➢ PTSD model:The role of trauma in causing the fragmentation of personality characteristic, which is supported by the available research. Support for the trauma theory comes from i. the finding that at least 98% of sufferers report trauma, ii. The finding that dissociation is general is associated with trauma, iii. The vast majority of individuals with DID also have PTSD, and iv. Some symptoms of PTSD are dissociative. ➢ The non-trauma theories (including iatrogenesis, or fantasy models) which suggest that DID is the result of a clinician suggesting the treatment and reinforcing it (iatrogenesis) or alternatively that individual with DID are highly fantasy-prone and reported trauma and abuse are fantasy rather than real. This approach however is not supported in the literature and it appears that DID does not have a sociocultural origin.	**DDD = CBT –** needs greater experimental support **Three phase of the International Society for the Study of Trauma and Disassociation's (ISSTD) guidelines for the treatment of DID** i. Build a trusting relationship ii. Confronting, working through and integrating traumatic memories (only when ready or risk re-traumatisation) - modified PTSD exposure therapies iii. Integration and rehabilitation - bringing together separate personalities (only a minority of patients achieve this end goal)
Social	**Predisposing Factors (vulnerabilities):** ➢ Physical or sexual and emotion abuse	➢

This document is available on studocu

Downloaded by moin khan (moinamb99@gmail.com)

Downloaded by moin khan (moinamb99@gmail.com)

Chapter 6

194. Mortality rate for people with anorexia nervosa is (18-20%**):**
a) extremely low.
b) 1 to 2 per cent per decade of illness.
c) 5 to 10 per cent per decade of illness.☺
d) 20 to 30 per cent per decade of illness.
e) 30 to 50 per cent per decade of illness.

195. One purpose of pro-anorexia websites is:
a) to provide a support group for sufferers of eating disorders.
b) to provide members with educational information about eating disorders.
c) to promote more healthy eating habits among members.
d) to actively promote anorexia nervosa as a life choice rather than a disorder. ☺
e) None of the given options are correct.

196. Studies examining the relationship between eating disorders and perfectionism have hypothesised that:
a) high levels of perfectionism are associated with eating disorders.☺
b) high levels of perfectionism are a result of having an eating disorder.
c) low levels of perfectionism are associated with eating disorders.
d) perfectionism is unrelated to eating disorders.
e) perfectionism is a poorly defined construct.

197. Evidence has found that antidepressant medication for anorexia nervosa:
a) improves mood and enhances weight gain.
b) improves mood but does not enhance weight gain.
c) improves eating difficulties but does not improve mood.
d) does not improve weight gain or eating difficulties. ☺
e) None of the given options are correct.

198. According to cognitive theorists, the most important cognitive aspect of dysfunctional thinking in people with anorexia nervosa is:
a) excessive reliance on others' opinions.
b) unrealistically low standards for themselves.
c) unrealistically high standards for others.
d) altered thyroid hormone metabolism.
e) dysfunctional self-evaluation, with over-emphasis on their shape and weight. ☺

199. In comparison with anorexia nervosa and bulimia nervosa, binge eating disorder does not include:
a) regular engagement in weight-control behaviours. ☺
b) low levels of perfectionism.
c) high levels of trait anxiety.
d) None of the given options are correct.
e) All of the given options are correct.

200. The DSM-5 specifies that bulimia nervosa:
a) cannot occur at the same time as binge eating disorder.
b) cannot include purging behaviour.
c) cannot occur at the same time as anorexia nervosa. ☺
d) be diagnosed very rarely because it is uncommon.
e) be diagnosed more often that it is because it is more common than was once thought.

201. The most common problem for patients with binge eating disorder is:
a) obesity. ☺
b) fluctuating electrolyte levels.
c) low-self esteem.
d) personality disorders. E) GA

206. Anorexia nervosa is more likely to develop in individuals who:
a) have low self-esteem.☺
b) are male.
c) are satisfied with their body shape and weight.
d) have high levels of leptin (a hormone which reduces food intake).
e) are initially obese.

207. Family therapy studies suggest that family therapy:
a) is not helpful for those with an eating disorder.
b) is helpful for those with a late onset of their eating disorder.
c) is helpful for those with an early onset of their eating disorder. ☺
d) actually reduces self-esteem.
e) None of the given options are correct.

208. It has been difficult to evaluate treatments for anorexia nervosa because:
a) the disorder is relatively rare.
b) effective treatments are long term and dropping out is an issue.
c) the disorder is relatively rare, effective treatments are long term and dropping out is an issue. ☺
d) treatments are short term and therefore difficult to evaluate.
e) None of the given options are correct.

209. The DSM-5 includes avoidant/restrictive food intake disorder. The key feature is:
a) amenorrhoea.
b) an intense fear of weight gain.
c) an eating disturbance where nutritional needs are not met. ☺
d) All of the given options are correct.
e) None of the given options are correct.

210. Current limitations in the treatment of eating disorders include:
f) limitations in treatments available.
g) identifying how best to assist those who resist treatment.
h) identifying ways of preventing eating disorders.
i) a greater understanding of eating disorders in men.
j) All of the given options are correct. ☺

211. Which statement is the most accurate with regard to the treatment of bulimia nervosa?
a) Antidepressant medication is more effective than placebo in reducing binge eating.
b) Cognitive behaviour therapy is more effective than antidepressants in reducing binge eating.
c) Medication is associated with high drop-out rates.
d) Medication is associated with high relapse rates.
e) All of the given options are correct. ☺

212. Preliminary studies have suggested that motivational enhancement therapy:
a) improves self-esteem and motivation. ☺
b) decreases self-esteem and motivation.
c) improves self-esteem but decreases motivation.
d) decreases self-esteem but increases motivation.
e) None of the given options are correct.

213. Historically the term 'anorexia' refers to:
a) neurosis.
b) mixed depression and anxiety.
c) loss of appetite. ☺
d) abnormal eating behaviour.
e) refusal to eat.

214. The Dual Pathway Model of bulimia nervosa suggests that

This document is available on studocu

Downloaded by moin khan (moinamb99@gmail.com)

202. The DSM-5 uses less strict criteria for the diagnosis of anorexia nervosa, bulimia nervosa and binge eating disorder. This should:

a) result in an overdiagnosis of these disorders.
b) result in an underdiagnosis of these disorders.
c) reduce the number of individuals falling into the residual eating disorder categories. ☺
d) increase the number of individuals falling into the residual eating disorder categories.
e) None of the given options are correct.

203. A 1999 study of children's responses to their parents' weight-related comments and modelling of weight-related behaviours revealed that:

a) girls were influenced by comments but not by modelling.
b) girls were influenced by modelling but not by comments.
c) boys were influenced by comments but not by modelling. ☺
d) boys were influenced by modelling but not by comments.
e) None of the given options are correct.

204. Bulimia nervosa differs from the binge eating/purging variant of anorexia nervosa in that:

a) people with bulimia nervosa are not overweight.
b) people with bulimia nervosa are not underweight. ☺
c) people with bulimia nervosa do not overemphasise shape and weight.
d) all of the given options are correct.
e) none of the given options are correct.

205. For a diagnosis of anorexia nervosa to be made, the individual must demonstrate:

a) body weight below 85 per cent of the expected weight for their age and height.
b) characteristic cognitive distortions including body image distortion and intense fear of weight gain.
c) intense fear of gaining weight.
d) None of the given options are correct.
e) All of the given options are correct. ☺

binge eating episodes are triggered by:

a) dieting.
b) negative affect.
c) interaction between dieting and negative affect. ☺
d) All of the given options are correct.
e) None of the given options are correct.

215. Anorexia nervosa is:

a) ten times as common in females as in males. ☺
b) twice as common in females as in males.
c) equally common in males and in females.
d) twice as common in males as in females.
e) ten times as common in males as in females.

216. Pica refers to:

a) constant eating.
b) refusal to eat.
c) eating only fluids.
d) eating non-foods. ☺
e) chewing food excessively

217. Rumination disorder refers to:

a) hiding food.
b) obsessing about eating behaviours.
c) regurgitation of food. ☺
d) eating non-food.
e) None of the given options are correct.

218. Twin studies have shown that anorexia nervosa is:

a) highly heritable (strong genetic component).
b) moderately heritable. ☺
c) mildly heritable.
d) not heritable (no genetic component).
e) only heritable among males.

219. Why is normalising eating and weight an essential first stage in the treatment of anorexia nervosa before other psychological problems (e.g. negative mood) can be addressed?

By primarily focusing on weight gain you fail to adequately address the underlying psychological aspects of the disorder (the 'nervosa'), however many psychological problems are the consequences of starvation so food and weight themes should be addressed first.

220. What similarities and differences are observed between AN and BN patients?

Both are western culture disorders involving self-evaluation based on body image and the attempt to obtain weight loss standards with body image disturbance (unable to see their actual size – worse in AN) which can be baffling for families and treatment teams. However, AN patients achieve weight loss (less than 85% of normal for weight and height), if they binge and purge it is less regular than for BN. Importantly BN has heightened feeling of shame and being out of control while AN are carefully controlled, fearing being out of control.

Downloaded by moin khan (moinamb99@gmail.com)

Anorexia Nervosa (AN)

Prevalence	Age of onset	Gender difference	Mortality
0.5-1.6% of females 0.1% males (US and NZ <1% 0.9)	˜age 13 or early adolescence 40% of cases 15-19 years	90% of sufferers are white females 10:1 female to male	18-20% mortality rate (50% suicide 50% starvation) 5 to 10 per cent per decade of illness

DSM-5: Criteria
- ✓ Relentless drive for thinness - body weight below 85 per cent of the expected weight for their age and height.
- ✓ Characteristic cognitive distortions including body image distortion and intense fear of weight gain.
- ✓ Subtypes - restricting calories & binge-purge

Progression Poorest prog. longest duration, binge-purge & OCPD, limited treatment gains, high relapse.47% fully recover 1/3 improve 20% remain chronically ill.

Comorbidity

- Medical and psychological complications of starvation – depression, mood swings, irritability, anger, self-harm
- Psychological comorbidities: Mood disorders (Inc. MDD) & Anxiety disorders (inc. social phobia) Personality disorders (Inc. OCPD)/Substance use disorder (Inc. amphetamines).50% develop bulimia

Dysfunction

- ➢ Clinically significant distress – fear of weight gain
- ➢ Physical dysfunction: Lanugo, hair loss, brittle nails sensitivity to cold, headaches, immune & endocrine dysfunction, cardiovascular problems (irregular rhythms or heart failure) brain shrinkage (reversible) Women: Amenorrhea

	Aetiology	Treatment
Biological	**Predisposing Factors (vulnerabilities):** ✓ Genes make a moderate contribution but don't account for body dissatisfaction. ✓ Family history of leanness, OCPD or depression common (NOT SUBSTANCE ABUSE AS IN BN – supporting the distinction) ✓ Focus on unusually high 5-HT activity and hormones (e.g., leptin) related to appetite and fullness. ✓ Role for epigenetics – maternal stress and poor nutrition ✓ Potentially neurobiological abnormality -temporal lobe and limbic system	➢ Medical – involuntary if life threatening, to re-establish food intake and weight ➢ Pharmacological: antidepressants are only indicated in cases of major depression (SSRI's) but tricyclics should be avoided as they may affect cardiac functioning.
Psychological	**Predisposing Factors (vulnerabilities):** ✓ low self-esteem and body dissatisfaction, ✓ mood disturbance (negative emotions) ✓ personality traits such as perfectionism. **Precipitating factors (Stressors):** ➢ Often precipitated by a stressful life event. **Perpetuating factors (maintaining):** ➢ self-esteem linked to shape and weight ➢ Negative affect Coping mechanism for anxiety or depression– taking control/cry for help and attention ➢ Dysfunctional thinking about eating, body shape and weight – distorted body image ➢ Terrified of eating ➢ Value placed on disorder– not motivated to change	➢ **MET** – develop motivation to change. MET attempts to achieve this through methods such as decisional analysis sheets (pros & cons) aimed at making people more aware of the negative consequences of AN ➢ **CBT** - stage 1 Instituting a meal plan (behavioural strategy), stage 2 challenge dysfunctional beliefs and restructure with more realistic beliefs and overcome beliefs sense of self-worth (silence the inner critic) (cognitive strategy), Stage 3 relapse prevention - identifying periods of vulnerability and early warning signs and developing cooping strategies (ie return to therapy)
Social – Relationships	**sociocultural approach** **Predisposing Factors (vulnerabilities):**	➢ **Family therapy** – treatment of choice for younger patients (though CBT also promising) –

This document is available on studocu

Downloaded by moin khan (moinamb99@gmail.com)

(Micro & meso systems)	✓ Difficult to differentiate between cause and effect – deterioration of family functioning due to AN ✓ Individuals with AN report families are highly critical and offer lower levels of care and affection – cry for help ✓ Family behaviours and attitudes around eating ✓ Parent's negative comments around weight influence boys and girls ✓ Modelling of parent behaviour (maternal dieting) – influences girls only **Precipitating factors (stressors):** ✓ Stressful life events – loss of family member, friendships, family disharmony ✓ Adolescence is period of developmental transition growing importance of peers/seeking of peer approval	➢ **Maudsley Model** – rather than inpatients and day patient treatment which disrupt everyday life being with refeeding and weight gain by promoting <u>healthy eating at home</u> and then working towards personal autonomy and on establishing new patterns of <u>family relationship</u> that do not revolve around disordered eating. Best for those under 19 years with 3 years of AN – in total 2/3 of adolescents with AN recover following FT 75-90% fully weight recovered at 5 year follow up.
Social-Environment (exo, macro and chrono systems	**<u>sociocultural approach</u>** = consider culture and social institutions to understand the causes of abnormality (1/4 models meet weight criteria for anorexia) media portrays of unrealistic and unhealthy levels of thinness as the ideal for female beauty **Predisposing & perpetuating factors:** ✓ Western culturally bound disorder - cultural attitudes to importance of thinness – spreads to other cultures (Fiji) with exposure to western stereotypes of beauty ✓ Historic period – 21st century western ideals of beauty More common in second half of 20th century **Precipitating factors** ✓ Stressful life events – Change schools, move house, loss of support service ✓ Pro-anorexia websites perpetuate the idealised state of emaciation and even a single viewing result in a negative influence on mood, self-esteem and body image	➢ Community level prevention campaigns

Downloaded by moin khan (moinamb99@gmail.com)

Bulimia Nervosa (BN)

Prevalence	Age of onset	Gender difference	Mortality
Increased since 1970's but recently stabilised even fallen	Late adolescence and young adulthood. ~16-19 years Older age of onset for men	1-3% of women versus 0.1-0.3% of men Under diagnosis in men in general less likely to present Homosexuality is a risk factor	Far lower than AN but under researched

DSM-5: Criteria

- ✓ Recurrent episodes of binge eating : Eating more than most people would eat & a sense of lack of control over eating
- ✓ Recurrent inappropriate compensatory behaviour in order to prevent weight gain
- ✓ The binge eating and inappropriate compensatory behaviours both occur, on average, at least once a week for three months.
- ✓ Self-evaluation is unduly influenced by body shape and weight.
- ✓ The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

Progression Can become chronic if untreated- 50% have the disorder after 10 years. Poorer outcomes; early history of obesity, low self-esteem or personality disorder

Comorbidity	Dysfunction
• Medical and physiological complications due to purging • Psychological comorbidities include depression, anxiety, personality disorders and substance use disorders	➢ Fewer medical complications than AN ➢ Main concern purging leads to electrolyte imbalances = weakness tiredness constipation depression irregular heart beat & death ➢ Also acid from vomit leads to ulceration and dental decay Intestinal problems ➢ Salivary gland enlargement & calluses from frequent vomiting

	Aetiology	Treatment
Biological	**Predisposing Factors (vulnerabilities):** ➢ Moderate heritability ➢ Family history of obesity, substance abuse or mood disorders common (NOT OCPD AS IN AN – supporting distinction) ➢ Focus on reduced 5-HT leading to increased appetite ➢ Role for epigenetics – maternal stress or over nutrition in utero	➢ Restore normal eating patterns & address malnutrition ➢ Pharmacological approaches in the form of antidepressants are supported by the research however CBT achieves greater results with less drop out or relapse, so CBT should be attempted first.
Psychological	**Predisposing Factors (vulnerabilities):** ➢ Negative affect **Precipitating factors (Stressors):** ➢ Often precipitated by a stressful life event. **Perpetuating factors (maintaining):** ➢ Self-evaluation unduly influenced by body weight and shape ➢ Over focus on appearance ➢ **Dual pathway model** two factors trigger binge eating 1. Dieting (hunger starvation and craving) and 2. Negative affect (food as self-medication) ..binge eating then increases dieting and correspondingly the negative affect perpetuating the disorder – vicious cycle	➢ Reduce relapse risk, address related psychological difficulties ➢ CBT is the treatment of choice to BN- however substantial numbers continue to experience symptoms. ➢ Formal CBT includes three phases – 1. psychoeducation to eliminate dieting and establish regular eating patterns with coping strategies for binge urges taught and self-monitoring 2. Eliminate all dieting and target dysfunctional cognitions, reintroduce forbidden foods as 'sometimes' foods as part of a balanced diet. Stage 3. Relapse prevention ➢ MET may be used first to increase motivation- BN sufferers are attached to "thinness" not to bingeing ➢ Guided Self-help CBT options may be attempted before therapy follow up in motivated individual
Social – Relationships	**Predisposing Factors (vulnerabilities):** ✓ Difficult to differentiate between cause and effect –	➢ **Interpersonal psychotherapy (IPT**) – interpersonal problems act as precipitating and perpetuating factors of BN and IPT helps people identify and change current

This document is available on studocu

Downloaded by moin khan (moinamb99@gmail.com)

(Micro & meso systems)	deterioration of family functioning in family with child with BN ✓ individuals with AN report families are highly critical and offer lower levels of care and affection – cry for help ✓ Maternal history of dieting ✓ negative comments regarding shape or weight **Precipitating factors (stressors)& Perpetuating factors:** ✓ Interpersonal problems act precipitating factors for binge eating ✓ critical, hostile & rejecting comments ✓ negative comments regarding shape or weight	interpersonal problems and identifying the relationship between the two
Social-Environment (exo, macro and chrono systems	**Predisposing & perpetuating factors:** ✓ Western culturally bound disorder - cultural attitudes to importance of thinness – spreads to other cultures (Fiji) with exposure to western stereotypes of beauty ✓ Historic period – 21st century western ideals of beauty More common in second half of 20th century **Precipitating factors** ✓ Stressful life events – Change schools, move house, loss of support service	Community level prevention campaigns

221. According to the dual pathway model of bulimia nervosa, what are the two main triggers of binge eating episodes?

Dual pathway model two factors trigger binge eating 1. Dieting (hunger starvation and craving) and 2. Negative affect (food as self-medication) ..binge eating then increases dieting and correspondingly the negative affect perpetuating the disorder – vicious cycle

222. What are some key differences in the epidemiology of binge eating disorder versus anorexia nervosa and bulimia nervosa?

In the aetiology of AN & BN, AN is linked to family history of OCPD and BN is linked instead to obesity and substance abuse family history

223. What are the main differences between bulimia nervosa and binge eating disorder?

While like bulimia, in terms of criteria of binge eating episodes at least once weekly for three months, and in severity specifiers (mild, moderate, severe and extreme) however binge eating disorder differs from bulimia in that there are no weight control behaviours adopted.

Downloaded by moin khan (moinamb99@gmail.com)

Binge Eating Disorder (BED)

Prevalence	Age of onset	Gender difference	Mortality
3-5% of young women	Older age of onset – young to middle age adults . Even across ages	2/3 women 1/3 men (3:1)	Heightened risk of lifestyle illnesses which are leading course of death in western world

DSM-5: Criteria

- ✓ Binge eating at least once every week for three months accompanied by marked distress and plus three of these five
  - i. Eating more rapidly than normal
  - ii. Eating until uncomfortably full
  - iii. Eating when not hungry
  - iv. Eating alone because of embarrassment or feeling disgusted
  - v. Guilty or depressed after eating
- ✓ Not meet criteria for AN or BN

Progression

Comorbidity	Dysfunction
• More psychopathology vs. non-binging people who are obese	➢ Obesity and obesity related illness

	Aetiology	Treatment
Biological	**Predisposing Factors (vulnerabilities):** ➢ Moderate heritability ➢ Focus on 5-HT and hormonal disturbance (ghrelin) ➢ Dysregulation of the mesolimbic dopaminergic reward pathways	➢ Pharmacological therapies in the form of SSRI are supported by the research however CBT alone produces superior effects which are not increased but combined drug therapy.
Psychological	**Predisposing Factors (vulnerabilities)** ➢ Negative affect **Precipitating factors (Stressors):** **Perpetuating factors (maintaining):** ➢ Self-evaluation unduly influenced by body weight and shape ➢ Over focus on appearance ➢ Emotional eating ➢ **Dual pathway model** two factors trigger binge eating 1. Dieting (hunger starvation and craving) and 2. Negative affect (food as self-medication) ..binge eating then increases dieting and correspondingly the negative affect perpetuating the disorder – vicious cycle – however dieting is less importance and negative affect more important in BED	➢ Guided self help and self help CBT options have been found to be effective ➢ Formal CBT includes three phases – 1. psychoeducation to eliminate dieting and establish regular eating patterns with coping strategies for binge urges taught and self-monitoring 2. Eliminate all dieting and target dysfunctional cognitions, reintroduce forbidden foods as 'sometimes' foods as part of a balanced diet. Stage 3. Relapse prevention ➢ CBT and IPT have been found to be equally as effective in the treatment of BED, however whilst reducing binge eating behaviour no effect on weight loss has been observed and as 65% of people with BED have comorbid obesity, compared to 20% in the general population ➢ behavioural weight loss techniques should also be considered for those suffering comorbid obesity. These techniques include restricting calorific intake and increasing physical activity and do not require a psychologist as the therapist.
Social –	**Predisposing Factors (vulnerabilities):**	➢ Interpersonal psychotherapy (IPT) – interpersonal problems act as precipitating

This document is available on studocu

Downloaded by moin khan (moinamb99@gmail.com)

Relationships (Micro & meso systems)	✓ individuals with BED report families are highly critical and offer lower levels of care and affection – cry for help ✓ negative comments regarding shape or weight ✓ Obesity stigma and social rejection **Precipitating factors (stressors)& Perpetuating factors:** ✓ Interpersonal problems act precipitating factors for binge eating ✓ critical, hostile & rejecting comments ✓ negative comments regarding shape or weight ✓ Obesity stigma and social rejection	and perpetuating factors of BED and IPT helps people identify and change current interpersonal problems and identifying the relationship between the two
Social-Environment (exo, macro and chrono systems	**Predisposing & perpetuating factors:** **Precipitating factors** ✓	

224. What it is prevalence of eating disorders in Australia?

1 in 20 lifetime prevalence of any eating disorder = 15% of women. Mortality is highest of all psychiatric illness 12x rate of those without eating disorder.

225. What are some of the main limitations with current treatments for eating disorders?

- Lack of research on AN leaves therapists little guidance – scientist-practitioner model)
- While most encouraging results for CBT is for BN patients 50% still binge eat – need for including therapies to address interpersonal relationships = enhanced CBT
- Psychological interventions for BED do not result in weight loss, important for the health of those with obesity
- Availability of treatment and early interventions

Downloaded by moin khan (moinamb99@gmail.com)

226. How are drugs classified?

Drugs act on the central nervous system to alter mood, cognition and behaviour. Drugs are classified based on their effects on the CNS:

a. Depressants: (depresses CNS = alcohol & tranquilisers)
b. Stimulants: (stimulates CNS = caffeine, nicotine & cocaine)
c. Hallucinogens: (acts on CNS to alter perception = LSD, amphetamine and mescaline)

227. Define tolerance

Continued use of most psychoactive drugs lead to neuroadaptation in which a given dose produces a diminished rewarding effect. Lessened effects as a result of repeated administration (a higher dose is required)

228. What is withdrawal syndrome?

Withdrawal is the result of discontinued drug use by a long time user. Generally the effects are the opposite effect to drug use including sweating, tremors, agitation seizures and hallucinations called delirium tremens (DT's) and can be fatal.

229. Prior to the DSM-5, gambling disorder was classified as:
a) a personality disorder.
b) a disorder of impulse control. ☺
c) an anxiety disorder.
d) a mood disorder.
e) None of the given options are correct.

230. High levels of comorbidity of substance use disorders and other mental disorders have been explained by saying that:
a) people with mental health problems self-medicate with addictive substances.
b) mental health problems are caused (or made worse) by substance abuse.
c) both problems may have the same underlying cause(s).
d) All of the given options are correct. ☺
e) None of the given options are correct.

231. In the treatment of substance use disorders, medication can be useful to:
a) block the rewarding effects of the harmful substance.
b) substitute for the harmful substance.
c) reduce the severity of withdrawal symptoms.
d) All of the given options are correct. ☺
e) None of the given options are correct.

232. Which of the following is not a component of the Integrated Pathways Model of problem gambling?
a) behavioural conditioning
b) emotional vulnerability
c) biological factors
d) impulse dysregulation
e) None of the given options are components. ☺

233. Jacob's (1986) General Theory of Addiction asserts that:
a) addictions allow individuals to feel positive affect.
b) addictions allow individuals to escape painful realities and/or memories. ☺
c) addictions give people a sense of control.
d) None of the given options are correct.
e) All of the given options are correct.

241. 'Tolerance' of a substance refers to:
a) sociocultural acceptance that its use is normal.
b) spending a large amount of time obtaining or using it.
c) needing increasing amounts of the substance to get the same effect. ☺
d) needing decreasing amounts of the substance to get the same effect.
e) continuing substance use although it is causing problems.

242. Which of the following is not a criterion for gambling disorder?
a) a need to gamble with increasing amounts of money
b) lying to conceal extent of gambling
c) frequent gambling when feeling distressed
d) gambling when alone ☺
e) preoccupation with gambling

243. Which of these addictive substances is the one most commonly abused in Australia?
a) Alcohol ☺
b) cannabis
c) stimulants
d) opioids
e) hallucinogens

244. The Australian Gaming Council's figures for 2008-09 indicate that, on average, Australian adults spend how much per year on gambling?
a) approximately $10
b) approximately $100
c) approximately $1000 ☺
d) approximately $5000
e) approximately $10 000

245. In the neurochemistry of substances of dependence, the most important neurotransmitter is:
a) amphetamine.
b) dopamine. ☺
c) glutamate.
d) endorphin.
e) serotonin.

This document is available on studocu

Downloaded by moin khan (moinamb99@gmail.com)

234. A 2010 Australian report documented serious alcohol-related harm to the Australian community, with approximately what portion of the adult population reporting having been affected in some way by the drinking of others during the year of the study?

a) approximately 10 per cent
b) approximately 25 per cent
c) approximately 50 per cent
d) approximately 75 per cent ☺
e) approximately 90 per cent

235. It is generally accepted that the development of pathological gambling is due to:

a) biological factors.
b) psychological factors.
c) sociocultural factors.
d) All of the given options interacting. ☺
e) None of the given options are correct.

236. Substance use disorders cluster in families because:

a) substance use disorders are a product of culture.
b) substance use disorders have a strong genetic component.
c) children model their substance use on parents' behaviour and environment.
d) Both B and C are correct. ☺
e) All of the options given are correct.

237. A 1988 study of Gamblers Anonymous treatment outcomes found:

a) 50 per cent of participants had ceased gambling over a two-year period.
b) Less than 10 per cent had ceased gambling over a two-year period. ☺
c) very low dropout rates among participants.
d) very low dropout rates but only for men.
e) very low dropout rates but only for women.

238. PRIME theory of motivation relating to addictions has all of the following components except:

a) plans.
b) impulses.
c) responses.
d) evaluations.
e) procrastination.☺

239. Research from the United Kingdom has shown that those with a substance abuse disorder have a life expectancy approximately:

a) 5 years less than the general population.
b) 10 years less than the general population.
c) 14 years less than the general population. ☺
d) 20 years less than the general population.
e) 25 years less than the general population.

240. **'Withdrawal' from a substance refers to:**

a) substance use interfering with social or occupational functioning.
b) symptoms that emerge after reducing or stopping substance use. ☺
c) symptoms that emerge while using a substance.
d) unsuccessful attempts to reduce substance use.
e) needing increasing amounts of the substance to get the same effect.

246. Studies examining the effectiveness of pharmacological treatments for pathological gambling show mixed results. This may be due to:

a) high treatment dropout rates.
b) short follow-up periods.
c) a range of different measures used to measure outcome.
d) None of the given options are correct.
e) All of the given options are correct. ☺

247. In the DSM-5, pathological gambling may be classified as a behavioural addiction due to similarities between gambling and substance addictions with respect to:

a) clinical phenomenology.
b) aetiology.
c) comorbid conditions.
d) treatment.
e) All of the given options are correct. ☺

248. Substance use disorders are predominantly disorders of:

a) women.
b) young people. ☺
c) middle-aged people.
d) older people.
e) none of the given options;

249. Monozygotic twins have higher concordance rates for substance use disorder:

a) only for alcohol.
b) only for cannabis.
c) only for tobacco.
d) for alcohol, cannabis and tobacco. ☺
e) only for alcohol and only for males.

250. Compared to the general community in Australia, individuals who use methamphetamine are:

a) at the same risk of psychosis.
b) eleven times less likely to experience psychosis.
c) eleven times more likely to experience psychosis. ☺
d) unlikely to experience psychosis.
e) likely to experience a milder form of psychosis.

251. What percentage of gamblers suffer comorbid alcohol abuse?

a) 5 per cent.
b) 10 per cent
c) 20 per cent
d) 30 per cent
e) 40 per cent☺

252. With increasing age people are:

a) more susceptible to the effects of alcohol. ☺
b) less susceptible to the effects of alcohol.
c) just as susceptible to the effects of alcohol as younger people.
d) more susceptible but only for women.
e) more susceptible but only for men.

253. For people with mild drinking problems, treatment with the goal of controlled drinking (rather than abstinence) has been found to be:

a) more acceptable to patients than abstinence. ☺
b) less acceptable to patients than abstinence.
c) completely ineffective.
d) less effective than abstinence.
e) more effective than abstinence.

Downloaded by moin khan (moinamb99@gmail.com)

Substance Use Disorder

	Aetiology	Treatment
Biological	**Predisposing Factors (vulnerabilities):** ✓ Strong genetic component – adoption and MZ twin studies. ✓ First degrees relatives 8 x more likely to develop SUD **Perpetuating factors (maintaining):** ✓ Dysregulation of the mesolimbic dopaminergic pathways (VTA – NAc – Amygdala – hippo- ABG – PFC) ✓ Opioids agonise endogenous opioid receptors, the bodies response to pain ✓ Jellinek's Disease model of addiction – addiction as a medical disorder related to loss of control (removes blame but also self-efficacy) Inhibition dysregulation theory – reward pathways override inhibition responses PFC **Neurophysiological models:** ✓ Opponent process theory - The body strives to maintain homeostatic balance, moving away from extremes to seek a state of equilibrium ✓ Incentive sensitisation theory -Rewarding effects result from mesolimbic dopaminergic system absence of drug leads to incentive salient (craving) and withdrawal is unpleasant - evidence=LSD has no effect and appears not to result in tolerance	**Detoxification** – evaluation, stabilisation with medical support and treatment. May be useful first step. Similar relapse rates between those who detoxify and those who do not. **Pharmaco-therapeutic intervention** - use of 2nd drug, controlled supervised dose - potentially less harmful effects. i. Interventions to counteract or block the action e.g. **naltrexone** and **nalmefene** which reduces the pleasure associated with alcohol ii. Agonist – replace first drug e.g. **methadone, buprenophine** or **LAAM** (**antabuse** which antagonises the effects of acetaldehyde. iii. To mitigate or minimise the adverse consequences of the first drug or withdrawal symptoms, for example acamprosate helps people cope with withdrawal symptoms, but drinking must stop.

Prevalence	Age of onset	Gender difference	Mortality
Any substance use disorder 5.1% Comorbidity 35% 1 in 20 people. Ind Australia 12	Mean age (ABC dur PFC)	Mainly men	Life expectancy reduced by 14 years (UK stat)

DSM-5: Criteria

Minimum 2 symptoms from list of 11 (2-3 mild 4-5 moderate 6+ severe) with clinically significant distress

i. Larger amount used than intended
ii. Persistent desire or unsuccessful attempts to reduce use
iii. A lot of time spent obtaining, using & recovering
iv. Strong desires or cravings to use
v. Failure to fulfil role expectations
vi. Continued use despite social or interpersonal difficulties
vii. Reduced social occupational
viii. Use while physically hazardous
ix. Continued use despite awareness of problem
x. Tolerance (need more/diminished effect)
xi. Withdrawal (symptoms on cessation or avoiding these symptoms)

Progression Those who began drinking before age 14 were 3xtimes more likely to become drug dependent than those who did not start drinking until after 20.

Comorbidity

- High rate of psych comorbidity 35% of those with SUD have comorbid mental disorder – worse prognosis
- Meth users have 11 times higher risk of psychosis than GPop Increased risk of self-harm behaviours
- Polydrug use is common
- Medical conditions – liver cirrhosis, cancer, HIV, hepatitis,

Dysfunction

- Clinically significant distress
- Impact of others 75% of people affected by the drinking of others (16% family, 10% friends)
- Older people greater risk of falls, motor vehicle accidents and suicide (lower body concentration of water so higher BAC & concurrent medication use)
- Death: accidents, violence& suicide
- Heroin is commonly used out rates as a leading cause of death
- 15000pa smoking related deaths

	Aetiology	Treatment
Psychological	**Predisposing Factors (vulnerabilities)** ✓ Tri-dimensional personality theory – three dimensions of personality influence vulnerability = Novelty seeking (impulsivity), harm avoidance (seeking to avoid/alleviate negative symptoms) and reward dependence – Heavily **Precipitating factors (Stressors):** ✓ Skog's Choice Theory of Addiction - a rational choice to use substances following the weighing up the pro's and con's ✓ Outcome expectancy theory - Outcome expectancies are the anticipated positive and negative consequences of a given behaviour, for example they are what the individual believes will happen should they choose to use a drug. ✓ PRIME theory of motivation - our plans, responses, impulses motives and evaluations about use ✓ Beck's cognitive theory of substance use SUD as result of dysfunctional beliefs (I won't have friends if I don't try it/keep using it') = also important perpetuating factor) **Perpetuating factors (maintaining):** ✓ Classical conditioning – environmental and internal cues become conditioned and illicit cravings for AOD use (failure of tolerance!!) ✓ Operant conditioning – positive AOD use experiences (gain pleasure/reduce pain) reinforce use	Best attempted in context of Prochaska and Di Clementi's stages of change model – change is a non-linear progression, with setbacks creating a spiral shaped model – Pre-contemplation – contemplation – Preparation – Action – Maintenance – Relapse. Integrated with MI Motivational intervention (MI based on MET)– using a decisional balance sheet to help motivate people to quit Brief intervention - Early detection GP or ED referral for treatment involving two sessions of self-efficacy enhancement psychoeducation and a self-help booklet CBT -views excessive drug use as a maladaptive and avoidance form of coping with problems. It teaches skills to recognise and cope with high risk situations without resorting to drugs Relapse Prevention Marlatt's Cognitive behavioural model of relapse- initial use after abstinence is determined by the interaction of high risk situations, coping skills, self-efficacy, positive outcome expectancies and subsequent abstinence violation effect (evaluation – "it was a once off, this is hard" " I'm a user I have no control")
Social – Relationships (Micro & meso	**Predisposing Factors (vulnerabilities):** ✓ Family functioning including ineffective parenting (ineffective inconsistent discipline and parental modelling), negative communication (criticism) ✓ Parental modelling exerts the strongest effects – shapes outcome	➢ Internet based treatments avoid issues of stigma with retained anonymity

This document is available on studocu
Downloaded by moin khan (moinamb99@gmail.com)

Gambling Disorder

Prevalence	Age of onset	Gender difference	Mortality
Aust: 15% gamble regularly $19 billion pa ($1145papa)	12-14 years. 40% of adolescence gamble weekly 5% adolescence GUD 2.1% of adults (int. 1%)	More males than females. More women play bingo more men sports bet and casino table games. Equal rate of electronic games	1.7% of suicides

DSM-5: Previously an impulse control disorder now substance related and addictive disorder

Criteria Persistent recurrent problematic gambling leading to clinically significant impairment or distress and at least 4/9 symptoms in a one year period

i. Need to gamble with increasing $$ akin to tolerance
ii. Restlessness or irritability with reduced gambling akin to withdrawal
iii. Repeated unsuccessful attempts to quit
iv. Preoccupation with gambling
v. Frequent gambling because of distress
vi. After losing returning to get even (chasing losses)
vii. Lying to conceal extent of involvement
viii. Jeopardising or losing relationship, job, education or career opportunity due to gambling
ix. Rely on financial help from others

Progression Generally, gamble 1-10 years before gambling excessively women escalate quicker-mean treatment age 35-39. Multiple forms of gambling @ greater risk.

Winning phase – motivated by wins **losing phase** – motivated to recouple losses (chasing). **desperation phase –** any means to fund addiction

Comorbidity

- 80-90% personality disorder
- 75% MDD
- 40% comorbid disordered alcohol use
- 30% other SUD
- 14-40% antisocial personality traits

Dysfunction

- 1.7% of suicides gambling related – greatest risk with disclosure of debt, criminal offence or marital discord
- 60% commit an offence to finance gambling
- Financial, familiar and relationship dysfunction

Downloaded by moin khan (moinamb99@gmail.com)

	Aetiology	Treatment
Biological	**Predisposing Factors (vulnerabilities):** ➢ Inconclusive genetic evidence **Perpetuating factors (maintaining):** ➢ Similar dysregulation of mesolimbic dopaminergic pathway as SUD ➢ Low levels of 5-HT ➢ Noradrenaline turnover linked to arousal excitement, impulsive behaviour	Move to addiction model changes treatment focus to medical model <u>Pharmacological interventions</u> SSRI's (Comorbid MDD), opioid antagonists (naltrexone – comorbid AUD) and mood stabilisers (lithium – comorbid bipolar) shown to be potentially effective though none have specific approval for GD. High drop out rates
Psychological	**Predisposing Factors (vulnerabilities)** ➢ Personality disorders causally related ➢ Personality traits – sensation seeking ➢ Positive outcome expectancies **Perpetuating factors (maintaining):** <u>Operant condition</u>- role of positive and negative reinforcement <u>Classical conditioning</u> – environmental cues triggering craving <u>Cognitive models</u> – irrational beliefs despite statistical knowledge	<u>Classical conditioning based treatment</u> – cue exposure and aversion therapy negative imagery techniques ('imagine you are losing lot of money" are about 20-30% successful <u>CBT</u> – challenge and restructures dysfunctional beliefs and teach coping skills
Social – Relationships (Micro & meso systems)	**Predisposing Factors (vulnerabilities):** ➢ Modelling behaviour of parents (both parents 3x + g/parents 12x risk) (Social learning) ➢ Parental attitude to adolescent gambling <u>Jacob's General Theory of Addiction</u> - childhood social and developmental experiences leads to feelings of inadequacy low self-esteem, worthlessness which predisposes addictive behaviours – escape emotional pain and enter self-esteem enhancing fantasy **Precipitating factors (stressors)& Perpetuating factors:** ✓	➢ Gamblers anonymous – self-help groups with success rate around 7.5% and high dropout rate ➢ Education based programs for children teach resilience skills and enhance self esteem
Social-Environment (exo, macro and chrono systems	**Predisposing, perpetuating factors, precipitating factors** ✓ Social attitudes to gambling ✓ Regardless of biological or psychological predisposition you must be exposed to gambling = <u>Exposure model</u> ✓ As availability increases so does prevalence <u>Social learning theory</u> – exposure to glamorised media portrayals leads to vicarious learning	Public health model –reduce population based risk factors through public policy measures
	Integrated pathways model – a biopsychosocial approach recognising heterogeneity amongst gamblers <u>Pathway 1 behaviourally conditioned gamblers</u> – environment, social learning leads to gambling and cognitive evaluation (negative affect a consequence for this group not a precipitant) – high motivation for treatment, brief intervention is useful <u>Pathway 2emotionally vulnerable gambling</u> – dysfunctional cognitions and escape from stress leads to gambling – CBT useful <u>Pathway 3 – Biological based problem gamblers –</u> neurochemical dysfunction, benefit from pharmacological approach	

This document is available on Studocu
Downloaded by moin khan (moinamb99@gmail.com)

hological gamblers represent a heterogeneous group of individuals. What are the different subtypes of gamblers?

i. Non- gamblers
ii. Social, recreational and non-problem gamblers
iii. Problem gamblers – presence of harm irrespective of chronicity, severity or impact
iv. Disordered gambling – meeting DSM 5 criteria

255. What are the two reasons people are motivated to use AOD or gamble?

i. For positive reinforcement – to enhance positive mood (e.g. joy and pleasure)
ii. For negative reinforcement – to alleviate negative mood (depression, stress or boredom)

Downloaded by moin khan (moinamb99@gmail.com)

Lecture 8 Chapter 8 Sexual and relationship problems

256. Compare the linear model and the circular models of sexual function

The linear model is mainly used to explain males and functional females and suggests that an individual progress through 3 stages: desire, arousal and orgasm. For dysfunctional females, the circular model is suggested. The circular model (Basson, 2000) emphases that desire may not be the first stage, Initiation of sexual contact may result from other factors than desire and orgasm is not essential. May more accurately reflect women's experience. Critically influenced by context.

257. Describe McCabe's model for the development of sexual dysfunction within a relationship

Describes the interactions between developmental, individual and relationship factors and the cognitive evaluations/interpretations placed on these events which interacts bidirectionally with an emotional response and sexual dysfunction

If the meaning attached is associated with negative emotions and this is not adequately expressed to their partner, it can lead indirectly to sexual dysfunction

258. In terms of personality factors which of the following is not associated with relationship satisfaction?

a) low levels of neuroticism
b) high levels of agreeableness
c) conscientiousness
d) positive form of expression
e) low levels of anxiety ☺

259. In a 2000 study of partners who had been in a relationship for an average of 30 years, relationship satisfaction was most associated with:

a) lack of conflict.
b) the way in which conflict was managed. ☺
c) good sexual functioning.
d) low levels of self-disclosure.
e) All of the given options are correct.

260. Older men are more likely to suffer from:

a) premature ejaculation.
b) delayed ejaculation.
c) erectile dysfunction.(70y+ 64%) ☺
d) hypoactive sexual desire disorder. (70y+ 26%)
e) None of the given options are correct.

261. Men may become dissatisfied with medical treatments for erectile disorder because:

a) men do not experience the same level of arousal with a mechanically induced erection as self-stimulated erections.
b) medical treatments do not address the psychosexual components of an individual's sexual experience. ☺
c) medical treatments overlook relationship factors.
d) All of the given options are correct.
e) None of the given options are correct.

262. A condition is classified as a paraphilia if:

a) it causes significant distress.
b) harms others.
c) results in illegal activity.
d) interferes with relationships.
e) All of the given options are correct.☺

263. The medical model of treating men's erectile difficulties:

a) assumes that providing an erection will solve the sexual problem. ☺
b) addresses the psychosexual issues (such as subjective arousal).
c) addresses underlying relationship difficulties.
d) All of the given options are correct.
e) None the given options are correct.

264. Treatment programmes for sexual dysfunction have:

a) often lacked methodological rigour.
b) often lacked long-term follow-up.
c) often been too narrow in their approach.
d) All of the given options are correct. ☺
e) None of given options are correct.

265. The impact of incestuous sexual abuse on children is influenced by:

a) the quality of the child's relationships, both then and later
b) the length and severity of the abuse.
c) the way the child is treated at the time the abuse disclosed.
d) All of the given options are correct. ☺
e) None of the given options are correct.

This document is available on studocu

Downloaded by moin khan (moinamb99@gmail.com)

Sexual Dysfunction

DSM-5: Criteria

Stage of sexual response	Men	Women
Desire	**Male hypoactive sexual desire disorder 7%**	**Female sexual interest/arousal disorder** 30-50% **#**
Arousal	**Erectile disorder** 3% age 40-49 64% aged70-79 40%overall	
Orgasm	**Delayed ejaculation** 0-3% rare **Premature ejaculation** 5-8%	**Female orgasmic disorder** 24-51%
Pain		**Genito-pelvic pain/penetration disorder** 4%

#While disorders are still classified within a three-stage model, for the first time a condition spans two categories

Three subtypes: lifelong versus acquired
generalised versus situational
mild, moderate and severe (distress)

2/3rd of people who participate in behaviour approach (sensate focus) achieve overall improvement, when combined with CBT important cognitive factors are addressed but further research is required (results were about 60% but methodical weaknesses).. Large numbers fail to show improvement

	Aetiology SEE: McCabe's Model of sexual dysfunction with a relationship	**Treatment** Large dropout rates in research
Biological	➢ Positive sexual functioning associated with good health ➢ Male dysfunction linked to age disease and drug use ➢ Smokers, heart disease, hypertension & diabetes linked to erectile disorder ➢ Age increases risk of desire disorders and erectile dysfunction but not orgasmic disorders in men ➢ Those who remain physically active more likely to remain sexually active ➢ Antidepressant, antihypertensive drugs, tobacco, alcohol and recreational drugs are linked to sexual dysfunction	Drugs for men: Viagra BUT does not create subjective feelings of arousal which is also true of implants and injections. Viagra plus psychological therapy more effective than Viagra alone. Medical model seeks medical interventions for women (hormones – oestrogen and androgen) failing to consider psychosocial factors – not particularly effective
Psychological	➢ Positive sexual functioning associated with positive sexual self esteem ➢ Developmental experiences – sexual abuse and negative sexual messages in childhood lead to dysfunction ➢ Individual functioning = anxiety, depression, body image or stress ➢ Performance anxiety	Behavioural therapies – education, communication skills training and sensate focus exercises (Masters and Johnson technique – beginning with body pleasuring and later genital body pleasuring in the absence of intercourse – learn to communicate preferred experiences, both receive pleasure without anxiety or pressure to perform (ie no orgasm), focus on sensations rather than negative thoughts and provide the couple a positive interaction (goal – removal of performance anxiety) **CBT =** challenge unrealistic beliefs contributing to sexual dysfunction **Internet based treatment –** overcome distance and embarrassment (psychoeducation/mindfulness/sensate focus/sensate focus/erotica
Social – Relationships (Micro & meso systems)	➢ Positive sexual functioning associated with sexually skilful partner ➢ Strong relationship between relationship satisfaction and sexual satisfaction ➢ Psychological factors brought into a relationship (depression leading to lack of desire leads to partners feeling of withdrawal and rejection) ➢ Interpretations made of actions of partners (erectile dysfunction as rejection) ➢ Erectile dysfunction increases with age but faster for the unemployed ➢ Partner rejection & marital conflict – communication problems and lack of intimacy ➢ Relationship difficulties can be a cause and a consequence of sexual dysfunction	➢ **Relationship therapies – combining relationship and sex therapy is more effective than sex therapy alone** ➢ Addressing levels of conflict, support, emotional intimacy, cognitive and affective styles

Disorder	**Paraphilic Disorders - DSM criteria and description**

Downloaded by moin khan (moinamb99@gmail.com)

	Difference between a paraphilia ad a paraphilic disorder is the disorder must have negative consequences such as distress or risk of harm – so a non-normative behaviour versus psychopathology – must consider the very wide range of normal sexual behaviour (socially bound concept)
Exhibitionistic	Intense arousal from exposing genitals to involuntary observers, for at least 6 months accompanied by marked distress and interpersonal problems. Arousal results from the fear, disgust and shock of other. Mostly male with large numbers of females at least once
Fetishistic	The use of non-living objects (i.e. women shoes, stockings etc.) or highly specific non-genital body parts (toes, hair etc.) to obtain arousal
Frotteuristic	Obtaining sexual gratification by touching or rubbing a non-consenting person, often in crowded places (trains, queue etc.), generally young males who grow out of it
Paedophilic	Intense, recurrent fantasies or urges or sexual activity with pre-pubescent children or either sex. Must be at least 16 years of age and child must be at least 5 years younger Immature personality and poorly developed interpersonal skills – mostly know their victim. Many were abused as children but most victims do not become paedophiles - Higher levels of psychopathology (i.e. paranoia, sexual obsessiveness and dysfunction) – grossly underestimated prevalence rate - Incest links – step-father, traditional family structure (dominant father, submissive mother, obedient children), non-affectionate mother, low SES, victim few friends
Sadistic	Sexual arousal from the physical or psychological suffering of others – non-consenting or willing collaborator -more males
Masochistic	Excitement from being the recipient of humiliation, beatings, bondage or other suffering – more males
Transvestic	Sexual arousal from cross dressing (not gender identity disorder – trapped in the body of opposite sex) – generally heterosexual men with few sexual partners. Commences in childhood or adolescence and can include gender dysphoria (gender confusion)
Voyeristic	Sexual arousal from watching others, generally strangers, undressing or having sex while the voyeur masturbates or later masturbates on the memory. Enjoys the risk and secret nature. May fanaticise about a relationship but this rarely eventuates. Develops prior to 15 years but need to be 18 for diagnosis

	Aetiology	**Treatment**
Biological		Reduce the sex drive through medical options – chemical or surgical castration but only in conjunction with psychological treatment
Psychological	Psychoanalytic and learning explanations – childhood experiences Mother may wear high heels and stockings and this transfers to a fetish in adulthood	Behaviour therapies – aversion to reduce the association (*imagine a very smelly shoe covered in fungus*) and exposure therapy to reduce anxiety in the absence of the paraphilic focus (exposure to positive fantasies sexual activity with non-paraphillic objects)
Social – Rel	Highly comorbid anxiety, mood, substance abuse disorders other paraphilia's	Social skills training – learn to interact in comfortable and pleasant way with others

Relationship problems

	Aetiology	**Treatment**
Biological	Hormonal disturbance – stress hormone levels predict divorce Sexual satisfaction related to relationship satisfaction (communication a better predictor)-more so for women	Psychological – <u>Distressed couples don't often benefit</u> from treatment -wait too long 30% relapse 38% divorce
Psychological	Personality factors - Relationship satisfaction is associated with lower levels of neuroticism, higher levels of agreeableness (please others), conscientiousness (goal directed) and positive forms of expression (open and pleasant) Cognitive factors – better to have a realistic view of your partner than an optimistic view. Attributional style - accurately attribute causes of actions Lifespan perspective – living longer relationships change	<u>Behavioural approaches</u> – behaviour exchange (bringing a cup of coffee in the morning, communication training and skills training <u>CBT –</u> challenging dysfunctional cognitions, communication and skills training (coping skills) Expressive and receptive listening skills
Social – Relationships	Relationship dynamics - Self-disclosure needs to be high and secrecy low for relationship satisfaction as does avoidance of conflict issues. Higher levels of early conflict predict later problems – conflict leads to negative perceptions, criticism and interruption	Couple therapy for homosexual couples to address unique strains
Social- Env	Becoming a parent – negative association between parenthood and relationship satisfaction Work and the negotiation of roles and the division of labour	➢ Consider childcare to provide a break for mother

This document is available on studocu

Downloaded by moin khan (moinamb99@gmail.com)

266. **The DSM classification of paraphilic behaviours as mental disorders has been criticised by some as being**:
a) based on moral views rather than psychiatric concerns.
b) based on ethical views rather than psychiatric concerns.
c) based on legal views rather than psychiatric concerns.
d) based on values rather than psychiatric concerns.
e) All of the options given are correct. ☺

267. What % of newlyweds reported at lea relationship violence
a) 5
b) 10
c) 15
d) 20 ☺
e) 25

268. With regard to models of sexual dysfunction:
a) a circular model may be more appropriate for women ☺
b) a circular model may be more appropriate for men
c) a circular model may be more appropriate for both sexes.
d) All of the given options are correct.
e) None of the given options are correct.

269. In transvestic fetishism:
a) a man believes that he is a woman in a man's body.
b) a woman believes that she is a man in a woman's body.
c) a man is sexually aroused by dressing in women's clothing☺.
d) a woman is sexually aroused by dressing in men's clothing.
e) a man is sexual aroused by women's shoes.

270. Among other things, the McCabe (1991) model of the causes of sexual dysfunction suggests that:
a) sexual dysfunction may contribute to relationship problems.
b) relationship problems may contribute to sexual dysfunction.
c) sexual dysfunction is unrelated to relationship problems.
d) sexual dysfunction may contribute to relationship problems, but relationship problems may also contribute to sexual dysfunction. ☺
e) None of the given options are correct.

271. For women's sexual difficulties, pharmacotherapy:
a) has been studied more in recently and is highly effective.
b) has been studied more in recently, with limited success. ☺
c) has been studied less in recent years.
d) found to be more effective for women than for men.
e) None of the given options are correct.

272. Cognitive behaviour therapy for sexual dysfunction focuses on:
a) exploring traumatic childhood experiences.
b) challenging unrealistic beliefs ☺
c) a graded series of sensate focus exercises.
d) achieving a better sexual response by medication.
e) None of the given options are correct.

273. A significant change for women in the DSM-5 is that the interest and arousal phases have been combined into a single disorder. This is:
a) hyposexual desire disorder.
b) dyspareunia.
c) sexual arousal disorder.
d) female sexual interest/arousal disorder. ☺

274. In a 2013 study of Australian men the prevalence rate for erectile dysfunction disorder was:
a) 10 per cent.
b) 20 per cent.
c) 25 per cent.
d) 40 per cent. ☺ average increased by high rate in over 70s
e) 50 per cent.

275. In the Middle Ages, paraphilias were thought to be:
a) due to defective psychosexual development.
b) illnesses.
c) caused by supernatural forces (witches or demons). ☺
d) due to childhood trauma.
e) due to parental influence.

276. In exhibitionism, the person exposes their genitals to an involuntary observer and obtains gratification from:
a) doing this in a different location each time
b) physical contact with the observer.
c) the observer's positive reaction.
d) the observer's negative reaction. ☺
e) None of the given options is correct.

277. Psych research explains marital problems in terms of:
a) individual spouses' personality characteristics.
b) spouses' perceptions of their partner's personality characteristics.
c) negative patterns of interaction between spouses.
d) All of the given options are correct. ☺
e) None of the given options are correct.

278. Internet-based treatment for sexual dysfunction suggests that it is most likely to be effective among:
a) men.
b) women.
c) older adults.
d) younger adults.
e) individuals with a high level of motivation to resolve their sexual problems. ☺

279. The difference between voyeurism (a paraphilia) and voyeuristic behaviour is that in voyeurism:
a) the victim is unaware they are being observed.
b) the behaviour is compulsive.
c) sexual arousal from observation is the person's main form of sexual gratification.
d) All of the given options are correct. ☺

280. Sensate focus exercises are often applied in the treatment of all sexual dysfunctions in order to:
a) help the couple broaden their approach to sexuality beyond a focus on intercourse.
b) reduce the threatening emphasis on performance.
c) de-emphasise the need to achieve orgasm.
d) help partners learn to communicate with one another.
e) All of the given options are correct. ☺

281. Which of the following is not one of Kaplan's stages of sexual functioning?
a) arousal c)desire e) all of above
b) orgasm d) dysfunction☺

Downloaded by moin khan (moinamb99@gmail.com)

Lecture 9 Chapter 9 Personality disorders

282. What are the five personality traits in the five factor model and the four higher order traits in Livesley's 18 Factor model and which is the better predictor of personality disorders?

Both models have found to significantly predict DSM-5 personality disorders but Livesley model better predicts antisocial, dependent, schizoid and schizotypal

283. Define personality

Personality is a persistent pattern of thinking and feeling ad behaving that is pervasive across situations and enduring over time.

284. Where is the division between normal and abnormal personality?

Personality exists on a continuum with no clear line between normality and pathology. Generally, those either very high or low in a trait are more likely to manifest a disordered behaviour, especially when experiencing a major life stressor, mental or physical illness. We all display these traits to a certain extent and it is only when they become problematic that they are cause for concern. While core personality generally maintains stability disordered personality is only moderately stable (i.e. higher impulsivity, self-harm, binge drinking in younger people than older adults

285. What are Millon's three core features that differentiate disordered personality from normal range problematic behaviours?

i. Functional inflexibility (rigidity =- failure adapt and to learn from experience)
ii. Self-defeating behaviour patterns (thoughts – difficulties maintaining relationships risky behaviours & substance misuse)
iii. Unstable functioning in the face of stress (tenuous stability under stress)

This document is available on studocu

Downloaded by moin khan (moinamb99@gmail.com)

Personality Disorders

Prevalence up to 13%	**Age of onset**	**Gender difference**	**Mortality**
6.5% in Australia. Over presented in clinical settings 25-40%. Each specific disorder 1-2% except OCPD which is 2-4% BPD = 2% (10% outpatient/24% inpatient)	Adolescence or early adulthood BPD may be considered a disorder of younger people with prevalence falling with age	males – antisocial and schizoid females – BPD, dependent & histrionic common or may reflect clinician bias	BPD suicide rate 10% with comorbidity

DSM-5 defines personality disorders as enduring patterns of perceiving, relating to and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts. • These patterns must differ from the individual's cultural group and cause significant personal distress and impairment in functioning

	Cluster A – Atypical odd or eccentric	**Cluster B – dramatic emotional flamboyant or erratic** (dramatic and confronting)	**Cluster C – anxious and fearful** (become reliant)
Description	(mistrusting of motives) High introversion Psychotic symptoms like schizophrenia Unlikely to seek treatment except in a crisis Paranoid – Extreme paranoia, hypervigilant, untrusting, unforgiving, doubt spousal fidelity, see malevolence where there is none. Sensitive to criticism, volatile tense Guilt, rage ,fear, shame +++ Schizoid – Extreme example of loner or computer nerd, no interest in having a connection with others, including sex. Emotionally cold and restricted range of emotions, Unaffected by praise or criticism. No perceptual disturbance – unlike schizotypal Schizotypal – discomfort with relationships – paranoia - disorganised speech and odd ideas (i.e. magical thinking) - positive and negative psychotic symptom (less severe than psychosis)	Antisocial – essentially conduct disorder in adulthood. Overt antisocial and criminal behaviour with a lack of remorse. Impulsive irritable and aggressive (75% prison populations. With ¼ of these displaying -**Psychopathy is not in DSM 5 but is closely related to antisocial PD = emotional detachment remorselessness desire for dominance manipulation and callousness – not limited to criminal or deviant behaviour can appear in well-adjusted successful people and may ever come to the attention of or researchers** Borderline (BPD)– Emotional instability, lack of sense of self, impulse control, self-destructive, self-harm (cutting etc), boredom, emptiness and extreme anger, may also experience paranoia or disassociation during stressful situations (Amy Winehouse) Histrionic – excessive attention seeking, want to be the centre of attention and use their sexuality to attract attention, shallow and easily influenced, judges relationships as more intense than they are (active dependence) Narcissistic – arrogant, concerned with own power and abilities – others are simply the audience to observe their greatness, distain, entitlement ad disregard	High neuroticism & introversion Avoidant A pattern of social inhibition, feeling of inadequacy, and hypersensitivity to negative evaluation (extreme social anxiety) Dependent Pattern clingy submissive behaviour related to an excessive need to be taken care of (passive) Obsessive-compulsive PD (OCPD) – rigid, moralistic, extremely perfectionistic, anxiety from disruption to routine, can be a hoarder or miserly with money – coping responses behaviours a coping strategy!!
Comorbidity Dysfunction	Assessment rarely undertaken in clinical setting (time consuming) as focus is on mental disorder such as depression but treatment can be compromised. Co-morbidity rates are high (with depression, anxiety, substance abuse, eating disorders…)	BPD - often comorbid mood, anxiety or substance use disorder –self-harm, parasuicidal tendencies BPD – greatest level of disability and handicap of PD's – persistent for years despite symptomatic improvement – highest use of medical services & psychological services	AvPD – social phobia OCPD – lowest level of disability unless presenting with comorbid disorder such as depression -often seek help for anxiety or mood disorders

Downloaded by moin khan (moinamb99@gmail.com)

	Aetiology Little is known of origins or development and lacking in empirical validation. But general accepted to be and interaction genetically acquired personality traits an environmental factors (predisposition)	Treatment No validated effective treatment for antisocial PD. Research lack control group is common
Biological	**Predisposing Factors (vulnerabilities):** ➢ Genetic basis of personality traits 40-60% - abnormal develops out of same array of genetic components and life events as normal personality – environment acts to influence the extent to which genetically predisposed personality is expressed (Livelsey) ➢ MAOA gene low expression, so increased MA circulation 5-HT, DA & NA = aggression ➢ CLUSTER A and schizophrenia share common genetic contribution with environmental trigger– epigenetic perspective!! – SchPD common in families of schizophrenics + same neurophysiological abnormality as schizophrenics (high DA).Links between paranoid PD and schizophrenia but only weak link with schizoid PD and schizophrenia ➢ HPA axis sensitisation as a result of negative life events ➢ Cluster B Family twin and adoption studies find a genetic contribution for antisocial PD (high impulsivity low 5-HT high testosterone = aggression low level of arousal, amygdala dysfunction = violence inhibition mechanism, executive function dysregulation PFC – indicated by IOWA gambling task = equivalent to PFC lesions). BPD limited genetic findings MZ twins 35% DZ twins 7%. Family history of psych disturbance. 5-HT link to impulse control. Limbic system dysregulation. NPD most highly heritable!!!(high extroversion low agreeableness	**Linehan's Biosocial Model – Dialectical behaviour therapy.** biopsychosocial approach (inc. Zen Buddhism) with Cochrane review endorsement as empirically validated treatment for **BPD** – primarily a biological dysregulation in the emotion regulation system (high arousal) conjunction with high neuroticism interacting with childhood deprivation, neglect and abuse "drastically invalidating environments". Treatment includes mindfulness, distress tolerance (acceptance of pain as part of everyday life), interpersonal effectiveness (relationship and assertiveness skills) and emotion regulation skills) = reduction in suicidal behaviours and hospital treatment Pharmacological therapy: Antipsychotic medications when required in cluster A PD's, SSRI's and low dose anxiolytic (anti-anxiety) medications - schizoid traits less likely to respond to medications **Young's Schema Therapy** – Core belief developed in childhood through the interaction of biological disposition and interpersonal stress become early maladaptive schema that consciously influence thoughts, emotions, bodily sensations and behaviours ("I worry I will be abandoned" "I shouldn't have to follow normal rules" "'I deserve to be punished if I make a mistake" = schema therapy aims to challenge these core beliefs and the strategies use to cope with them (schema surrender "its who I am" schema avoidance "won't think about that" or schema compensation" embody polar opposite) – can be used in conjunction with Eye Movement Desensitisation and reprocessing (EMDR) **Perpetuating factors** "*why should I change, nothing wrong*"
Psychological	**Predisposing Factors (vulnerabilities)** Genetically determined personality traits (Livesley) BPD (neuroticism) APD (impulsivity) **Precipitating factors (Stressors)/Perpetuating factors (maintaining):** Nature, timing and intensity of life events Trauma, neglect and deprivation in childhood – not specific to PD but range of conditions (anxiety, mood, psychosis substance use, eating disorders, PTSD (sexual abuse linked to BPD) Livesleys 18-factor model of personality explains pathological personality arising out of same processes as normal personality – gene environment interaction Beck's Cognitive Model. 1. Maladaptive core beliefs 2. Core beliefs interact with social information to maintain dysfunctional beliefs by filtering out inconsistent information and shaping ambiguous information to fit. **Ryles Cognitive Analytic theory** – an integration of cognitive therapy and an object–relations approach. combines cognitive and psychoanalytic therapies to assist with the internalised early relational experiences (reciprocal roles) that shape how people relate themselves and others	
Soc	**Predisposing Factors (vulnerabilities) -**Disrupted attachment with primary caregivers – BPD linked to insecure attachment style from inconsistent, neglectful or overly intensive parenting drastically invalidating environments Inherited personality traits common amongst family member in home environment For example adoption studies show aggression in offspring of AntiPD but stronger where poor adoptive environment - Culturally determined "dysfunction" of personality trait – chose to label it	➢ CBT – treatment of choice for Avoidant PD ➢ Social skills training ➢ Stigma that PD can't be treated is invalidated by modest positive results with BPD

This document is available on studocu

Downloaded by moin khan (moinamb99@gmail.com)

Downloaded by moin khan (moinamb99@gmail.com)

286. Cluster B personality disorders are defined in terms of:

a) anxious and fearful traits and behaviours.
b) odd or eccentric traits and behaviours.
c) dramatic, emotional or erratic traits and behaviours.☺
d) All of the given options are correct.
e) None of the given options are correct.

287. A recent review has reported that _____ therapy is the most empirically validated treatment for borderline personality disorder.

a) schema therapy
b) cognitive behaviour therapy
c) dialectical behaviour therapy ☺
d) cognitive therapy
e) behaviour therapy

288. How many personality disorders in DSM-5?

a) 5
b) 7
c) 10 ☺
d) 12
e) 18

289. With regard to antisocial personality disorder:

a) Cognitive behaviour therapy has been shown to be effective.
b) schema therapy has been shown to be effective.
c) behaviour therapy has been shown to be effective.
d) no single treatment approach has been shown to be effective.☺
e) None of the given options are correct.

290. Young's schema therapy model suggests that early maladaptive schemas:

a) develop in childhood and are strengthened by substance abuse.
b) develop in adult life and are strengthened by substance abuse.
c) develop in childhood and are strengthened by biased information processing.☺
d) develop in adult life and are strengthened by biased information processing.
e) None of the given options are correct.

291. Estimates of the degree to which various personality traits are inherited:

a) range from 40–60%. ☺
b) range from 20–30%.
c) range from 2–5%.
d) range from 1–2%
e) do not range at all—there is no genetic basis to personality.

299. In health and mental health settings, the personality disorder that interests and involves clinicians most is:

a) paranoid personality disorder.
b) narcissistic personality disorder.
c) obsessive-compulsive personality disorder.
d) histrionic personality disorder.
e) borderline personality disorder.☺

300. Which of the following is not part of the definition of personality?

a) a consistent pattern of thinking, feeling and behaving
b) enduring over time
c) pervasive across situations
d) having no genetic basis ☺
e) All of the given options are correct.

301. Which of the following is <u>not</u> one of the four higher-order factors proposed (by Livesey et al.) to underlie personalities and personality disorders?

a) emotional dysregulation
b) compulsivity
c) inhibitedness
d) openness to experience ☺
e) dissocial behaviour

302. According to Millon (1981), core features that differentiate disordered personality from normal-range problematic behaviours include:

a) functional inflexibility.
b) self-defeating patterns of behaviour.
c) unstable functioning in the face of stress.
d) All of the given options are correct.☺
e) None of the given options are correct.

303. Obsessive-compulsive personality disorder is typically characterised by all of the following except:

a) rigidity.
b) perfectionistic style.
c) miserly with money.
d) sense of inferiority. ☺
e) hoarding.

304. In Young's schema therapy, behavioural techniques aim to:

a) deal with the client's feelings and thoughts.
b) block images, thoughts and feelings.
c) get the client to react in the exact opposite manner to their schema.
d) alter the coping styles used by the client.
e) All of the given options are correct.

This document is available on studocu

Downloaded by moin khan (moinamb99@gmail.com)

292. The coping style of 'schema avoidance' involves:

a) blocking distressing aspects of content of schema☺
b) ruminating over the content of a schema.
c) challenging schematic content.
d) replacing one schema with another.
e) None of the given options are correct.

293. Few individuals with antisocial personality seek help for their difficulties. This is because:

a) they have poor insight into their difficulties.
b) they may deny their symptoms.
c) they may blame others for their behaviour.
d) All of the options given are correct☺.
e) None of the options given are correct.

294. The PD with the greatest levels of disability is:

a) dependent personality disorder.
b) schizoid personality disorder.
c) schizotypal personality disorder.
d) avoidant personality disorder.
e) borderline personality disorder. ☺

295. Which of the following is in The Five Factor Model of personality

a) openness to experience. ☺
b) orientation to the external environment.
c) obsessive-compulsiveness.
d) optimism.
e) perfectionism.

296. In Marsha Linehan's Biosocial Model, the disturbances of borderline personality disorder are primarily attributed to:

a) dysfunction in the emotion regulation system. ☺
b) drastically invalidating environments.
c) maladaptive coping strategies.
d) the reciprocal role procedure.
e) hormonal imbalances.

297. The Violence Inhibition Mechanism Model argues that psychopaths:

a) can identify emotion in others.
b) have difficulty identifying emotion in others. ☺
c) have difficulty inhibiting emotions.
d) never inhibit emotion.
e) None of the options given are correct.

298. Which of the following is not a typical feature of borderline personality disorder?

a) emotional instability
b) lack of sense of self or identity
c) impulsivity
d) arrogance ☺
e) self-destructive behaviours

305. The development of individuals' personalities (adaptive or pathological) is influenced and determined by:

a) peer interactions.
b) genetic predisposition.
c) the nature, timing and intensity of life events.
d) genetic predisposition and the nature, timing and intensity of life events. ☺
e) None of the given options are correct.

306. In the DSM-5, psychopathy:

a) is under the Cluster A disorders.
b) is under the Cluster B disorders.
c) is under the Cluster C disorders.
d) is not listed. ☺
e) None of the options given are correct.

307. The Personality Disorders Work Group proposed an overall rating of personality functioning for DSM-5 involving how many severity levels?

a) three
b) five ☺
c) seven
d) ten
e) twenty

308. Ryle's Cognitive analytic therapy is:

a) a type of cognitive behaviour therapy.
b) an integration of cognitive therapy and an object–relations approach ☺
c) behaviour therapy.
d) similar to psychoanalysis.
e) None of the given options are correct.

309. Women, more than men, are more likely to be diagnosed with:

a) antisocial personality disorder.
b) schizotypal personality disorder.
c) histrionic personality disorder. ☺
d) All of the given options are correct.
e) None of the given options is correct.

310. In cognitive models of psychological functioning, an organised collection of information in memory which operates automatically is called:

a) a schema or core belief. ☺
b) an obsession.
c) standard short-term CBT.
d) personality.
e) transference.

Downloaded by moin khan (moinamb99@gmail.com)

Lecture 10 Chapter 10 – Disorders of childhood

311. List some of the commonly reported problems of child behaviour identified by parents?

i. Somatic complaints
ii. Delinquent behaviour
iii. Attention problem
iv. Aggression problems
v. Social problems
vi. Withdrawn
vii. Anxious/depressed
viii. Thought problems

312. What are some challenges associated with research on psychological disordered in children?

a. Longitudinal research is required in order to understand developmental progression
b. Substantial comorbidities make teasing out factors affecting different disorders difficult
c. Challenge distinguishing normal from abnormal behaviour in children
d. Difficulty in expressing the difficulties children experience – what does this tantrum mean?
e. Labelling a disorder leads to stigma, over diagnosis and overmedication.

313. What are the two main categories of childhood disorder that are used to dichotomise psychological disorders in children listed in the DSM-V

Childhood disorders can be categorised into either:

a. externalising (under-controlled; behaviours directed at others) – with own diagnostic criteria such as ADHD
b. Internalised – (over controlled; feelings and states that are inner directed) – criteria are mostly the same as for adults, such as anxiety disorders

314. Name three cognitive tests used to assess executive function in children with ADHD

i. Stop task – X and O appear in random order of screen and child needs to select corresponding keys on computer, unless a tone is sounded and then they must refrain from selecting key (impulse inhibition)
ii. Trailmaking – two tasks similar to dot-to-dot, first A-B-C etc (baseline) second A-1-B-2-C-3 (ability to shift between tasks)
iii. Mazes – planning skill

315. What are the key characteristics of an externalising disorder?

Externalising disorders are a broad categorisation of childhood disorders that incudes disorders characterised by problems of under-control, where behaviours are directed at others (such as conduct disorder). Behaviours may be seen as oppositional, noncompliant, attention seeking and disruptive.

316. What are the key characteristics of an internalising disorder?

In contrast with externalising disorders, internalising disorders such as anxiety and depression are often described as over-controlled, where feeling and states are inner-directed.

I GOT 5 WRONG BUT DON'T KNOW IF I ALTERED THESE YET!!!I found one or two

317. A specific learning disorder is diagnosed when a child's academic achievement is below what is expected of his/her age. It cannot be diagnosed when:

a) the child also has an anxiety disorder.
b) the child also has a mood disorder.
c) the child has an intellectual disability. ☺
d) the child has ADHD.
e) the child is mute.

330. For a diagnosis of intellectual disability to be made, an individual must demonstrate:

a) cognitive deficits in intellectual functioning.
b) functional limitations in daily living, communication and social skills.
c) Both of the options given are correct. ☺
d) Either option given is correct, but only with IQ above 70.
e) Neither of the options given are correct.

331. The key feature of separation anxiety disorder:

a) increased fear in the presence of the attachment figure.
b) reduced fear in the presence of the attachment figure. ☺
c) that it is more common in younger children.
d) that the criteria are the same for children and adults.

This document is available on studocu

Downloaded by moin khan (moinamb99@gmail.com)

318. Stimulant medications such as methylphenidate (ritalin) increase the availability of:
a) dopamine. ☺
b) serotonin.
c) endorphins.
d) All of the given options are correct.
e) None of the given options are correct

319. A major criticism of the DSM-5 in terms of disorders of childhood is the fact that:
a) it treats children like small adults.
b) it does not take into account the dimensional nature of many childhood conditions. ☺
c) it adopts an aetiological approach.
d) it adopts a dimensional approach.
e) None of the given options are correct.

320. For a child to be diagnosed with attention-deficit/hyperactivity disorder, must demonstrate:
a) attention-deficit symptoms.
b) hyperactivity symptoms.
c) either (or both) attention-deficit or hyperactivity symptoms. ☺
d) both attention-deficit and hyperactivity symptoms.
e) None of the given options are correct.

321. The development and maintenance of separation anxiety disorder involves all of the following except:
a) a genetic component.
b) parental anxiety.
c) parenting style.
d) family conflict.
~~e) mutism.~~☺

322. The intervention of choice for separation anxiety disorder is:
a) conditioning.
b) parent management training.
c) cognitive behaviour therapy. ☺
d) the Feingold diet.
e) None of the given options are correct.

323. Patterson's Coercive Processes Model of the development of oppositional DD focuses on:
a) the child's temperament.
b) the child's frontal brain activation.
c) the impact of the androgen hormone on brain development.
d) the interaction between parent and child. ☺
e) None of the options given are correct.

324. One of the most common childhood disorders :
a) autism.
b) reading disorder. ☺
c) selective mutism.
d) Rett's disorder.
e) that it can only be diagnosed in older children

332. If a boy's father was reading disabled, that boy has a _____% probability of being reading disabled.
a) 5
b) 10
c) 20
d) 40
e) 50☺

333. When comparing primary and secondary enuresis:
a) primary enuresis is more likely to have a psychosocial cause.
b) secondary enuresis is more likely to have a psychosocial cause. ☺
c) primary enuresis occurs after the child has been dry for at least 6 months.
d) secondary enuresis occurs when the child has never been dry.
e) None of the given options are correct

334. Children with encopresis tend to have all of the following except:
a) anxiety and depressive symptoms.
b) attention difficulties.
c) social problems.
d) poor school performance.
e) an intellectual disability.☺

335. Many parents of children with separation anxiety disorder:
a) also show symptoms of anxiety, suggesting the familial inheritance of anxiety.
b) tend to model anxious behaviour and poor coping.
c) provide fewer opportunities for their child to confront and master fearful situations.
d) often inadvertently reinforce their child's anxiety.
e) All of the given options are correct.☺

336. In comparison with control children and those with conduct disorder, children with attention-deficit/hyperactivity disorder have been found to demonstrate:
a) no neuropsychological deficits.
b) deficits in auditory comprehension.
c) deficits in memory functioning.
d) deficits in executive functioning. ☺
e) deficits in auditory functioning.

337. A diagnosis of reading disorder cannot be made if the child's reading problem is due to:
a) general developmental disability.
b) sensory impairment.
c) lack of educational and sociocultural opportunities. ☺
d) any of the other factors listed here.
e) none of given options.

Downloaded by moin khan (moinamb99@gmail.com)

e) oppositional defiant disorder.

325. Among the anxiety disorders, the only diagnostic category which is specifically for children is:

a) generalised anxiety disorder.
b) specific phobia.
c) agoraphobia.
d) separation anxiety disorder. ☺
e) obsessive-compulsive disorder

326. In terms of oppositional defiant disorder, the current recommendations for the DSM-5 are to distinguish between:

a) hyperactive and impulsive symptoms.
b) positive and negative symptoms.
c) emotional and behavioural symptoms. ☺
d) All of the given options are correct.
e) None of the given options are correct.

327. Separation anxiety disorder has been re-classified from the category of 'disorders usually first diagnosed in infancy, childhood or adolescence' to:

a) mood disorders.
b) anxiety disorders. ☺
c) personality disorders.
d) somatoform disorders.
e) None of the given options are correct.

328. Which of the following is not true of oppositional defiant disorder?

a) Its prevalence declines through childhood and adolescence. ☺
b) It involves difficulty regulating emotion.
c) It involves a negative affective style.
d) It is more common in boys than in girls.
e) All of the given options are true of oppositional defiant disorder.

329. The commonest psychological disorders in children are categorised as:

a) other disorders of infancy, childhood and adolescence.
b) thought problems.
c) genetic or inherited difficulties.
d) internalising and externalising disorders. .☺
e) None of the given options are correct

338. The Australian Temperament Project indicated that children who subsequently develop conduct disorder clearly differ from other children by the age of:

a) 1–2 years.
b) 5–6 years. ☺
c) 8–10 years.
d) 12–14 years.
e) 15–18 years.

339. The treatment for children's problematic externalising behaviours with the strongest research support is:

a) conditioning.
b) parent management training. ☺
c) cognitive behaviour therapy.
d) the Feingold diet.
e) None of the given options are correct.

340. Selective mutism is now thought to be a variant of:

a) social phobia. ☺
b) autism.
c) post-traumatic stress disorder.
d) schizophrenia.
e) None of the given options are correct.

341. The range of pervasive developmental disorders may be subsumed under the autistic disorder category for DSM-5 because distinctions:

a) have been found to be inconsistent over time.
b) have been found to be variable across different research and clinical settings.
c) are often associated with symptom severity, language level or intelligence.
d) All of the given options are correct.
e) None of the given options is correct.

342. **Name four internalising disorders experienced in childhood and what are the difference in diagnostic criteria for depression compared with adults?**

a. Major depression – in childhood irritability rather than depressed mood, plus favour to make expected weight gains rather than weight loss.
b. Separation anxiety - only in childhood
c. Selective mutism – only in childhood
d. Disruptive mood dysregulation disorder (little research validity - turning a temper tantrum into a disorder).

343. When dealing with children what ethical considerations do you need to take into consideration?

Children represent a vulnerable group in society and as such we should always act in the best interest of the child. Children have a right to have a say in what they think should happen when adults are making decisions on their behalf and their opinions should be considered. Children rights should be upheld and they should be treated equally despite their country of origin, criminal record or any disability they may suffer.

This document is available on studocu
Downloaded by moin khan (moinamb99@gmail.com)

344. What are the different age groups/categories of minors?

- Infant birth -2 years
- Child 3-12 years
- Adolescent 13-18 years
- Emerging adults/late adolescence up to 25 years

345. When considering a case study of childhood what should you consider?

i. Equifinality – two individuals can experience divergent internal and external experiences but encounter similar outcomes
ii. Multifinality – two individuals can experience similar internal and external circumstances yet follow different developmental trajectories
iii. We only see people in a snap shot of their development and the context, internal and external, is required to tell us where they have come from as nothing is predetermined.
iv. Children have little control over their environment
v. Focus on cognitive and behavioural development – school readiness, age norms, stages, context (depressed or bullied?)
vi. Moral reasoning (right and wrong) develop over time and once the ability is gained can accountability be considered.
vii. What is expected at that age and stage of development?
viii. What is the context demanding? – children with lower SES with externalising symptoms have been found to carry forward sadness, anger, worry and jealousy throughout the day compared to those lower in externalising symptoms (they are distressed!!). In the case of anger when it is expressed this group feels better, indicating that possibly it is not safe in their environment to express other emotions such as sadness but anger is okay to express.

**346. Why is adolescence a risky time of life **

It is normal and functional in adolescence for children to seek increased autonomy, desire peer acceptance, have a greater exposure to drugs and alcohol and have an increased propensity to engage in risky behaviours. This thrill-seeking behaviour is hard to inhibit as subcortical development is taking place rapidly and reward seeking behaviours have greater salience. Therefore it can be seen that neural regions for incentive motivation and executive function (WM, inhibition, attention) are still developing. A lot of attention is given in the research to executive function however an understanding of the how executive function can be overridden but immature subcortical emotional structures.(EXECUTIVE FUNCTION IS THE CAPTAIN OF THE SHIP NOT THE ENGINE)

347. What are the different internalising and externalising disorders in DSM V

Internalising disorders: MDD – expressed as irritable mood, fail to meet weight gains (as opposed to weight loss in adulthood), Anxiety Disorders – may manifest as non-compliant, oppositional behaviour or somatic complaints (stomach aches etc. as no label for 'anxiety')
Externalising disorders: Oppositional defiant disorder "naughty child" – non-compliant failure to follow rules, needs treatment gets punishment - Conduct disorder: pattern of behaviour which violate social norms and disregard for these Disruptive mood regulation disorder severe recurrent outbursts – huge tantrums

348. What is the potential trajectory for people with ODD?

ODD can lead to CD and for those with childhood onset this could lead to antisocial personality disorder which is over represented in prison populations. Callous unemotional traits have been found to correlate with lifelong offending. (low empathy guilt shallow effect)

349. What treatment for elimination disorders has been found most effective?

Downloaded by moin khan (moinamb99@gmail.com)

Behavioural treatments have been found to be more effective than medical treatments for enuresis (wetting) or encopresis (soiling) including psychoeducation, conditioning (bell and pad)and behavioural reinforcement

This document is available on studocu

Downloaded by moin khan (moinamb99@gmail.com)

Neurodevelopmental Disorders

	prevalence	Gender difference	Onset	Progression	**Comorbidity**	**Aetiology & treatment Biopsychosocial**	
ADHD	Disorder marked by deficits in attention, controlling impulses and regulating activity levels						
	2% (pos 8.8% pre-schoolers)	Male more common than female Boys externalise Girls Internalise	Early childhood but also adolescence	May diminish with age or continue into adulthood (procrastination)	Highly comorbid with ODD	Biological	**Genetic contribution** stronger than for ODD and CD– neuropsychological impairment - impairment of inhibition or excitation of executive functioning (on-off-switch) - autonomic under arousal in pre-schoolers **Diet** – some evidence that aspartame, colours and flavours influence ADHD symptomology **Pharmacological therapies -** such as Ritalin increase DA availability and reduce over activity, impulsivity and inattention
						Psychological	lower response to reinforcement, need stronger motivators
						Social	Family and parenting variables include parental inconsistency and lack of involvement
Specific learning disorder	lower than expected performance in a particular area of learning relative to child's age and intellectual ability						
Reading Disorder	4-7% One of Most common Childhood disorders			Little chance of spontaneous recovery, leads to low grades, early school leaving and limited employment opportunity	ADHD and behaviour problems – but failure to learn not result of ADHD	Biological	**Genetic contribution** – some evidence 50% probability of boy having reading disorder if father does **Neuropsychological impairment -** phonological awareness, working memory and speed of processing written language – no evidence of low cognitive ability
						Psychological	Phonological (sounding out) and strategy based (whole word recognition) approaches – with assistance 3-6% don't respond and 50% can approx. up to speed
						Social	
Autism spectrum disorder	Characterised by impairments in social communication and interaction, and repetitive behaviours, interests and activities (new to DSM5 previously 4 separate disorders). Defined by severity Level 1 requiring support/ Level 2 requiring substantial support/Level 3 requiring very substantial support Core deficits: 1 communication (social-emotional reciprocity and difficulty with non-verbal communication) 2 deficits in theory of mind						
	1%	Male more common than female 2:1	Expressed between 3-5 years of age	75% poor outcomes – independent living and unemployment 25% good outcome linked to language skills 6 IQ 50+ & an area of strength (e.g. music or maths		Biological	**Genetic –** polygenetic with 60% concordance rates for MZ twins **Prenatal and perinatal insults –** maternal ill health **Environment –** no support for diet or vaccination involvement **Pharmacotherapy –** reduce aggression, irritability or hyperactivity or repetitive behaviours
						Psychological	Behaviour modification programs found to be effective in improving functioning – based on assessment, reinforcement procedures put in place to increase desirable and reduce undesirable behaviours
						Social	Social deprivation (Romanian orphans) explains small number of cases

Downloaded by moin khan (moinamb99@gmail.com)

	prevalence	Gender difference	Onset	Progression	Comorbidity	Aetiology & treatment Biopsychosocial	
Intellectual disability		A group of disorders characterised by deficit in intellectual and adaptive functioning. Includes deficits in intellectual functioning (IQ <65-75) deficits in adaptive functioning (independence and social responsibility), childhood onset. Severity rated as mild, moderate, sever or profound Range of disorders includes: epilepsy, cerebral palsy, sensory deficits, downs syndrome and pervasive developmental disorder (heterogeneity)					
	1%	More boys than girls	Age of onset determined by cause – some take time to develop	Childhood onset 85% have IQ within mild range. Progression depends on the Cause, with biomedical factors such as metabolic disorder (shortens lifespan) and psychosocial factors (access to therapy)	70% with comorbid anxiety depression	Biological	**Genes =** 500 genetic conditions are associated with intellectual disability (largest known causes) **Prenatal exposure:** alcohol, tobacco, maternal infection, low birth weight **Postnatal environment:** lead exposure and head injury **Treatment** - early intervention with metabolic conditions such as PKU. Physical therapy (motor coordination skills) occupational therapy (toileting etc) and speech therapy Identification of comorbid medical conditions
						Psychological	Vineland adaptive behaviour scale used to assess adaptive functioning skills including communication (express needs), daily living skills (hygiene) socialisation (coping skills) and motor skills
						Social	family support

350. Describe oppositional defiant disorder (ODD) and conduct disorder (CD)from a biopsychosocial perspective

ODD	Disorder of chronic misbehaviour in children marked by belligerence, irritability and defiance						
	3% one of most common 8% pre-schoolers	B/G 1.4/1 Boys argue Girls ignoring	More common amongst pre-schoolers	Longer it persists increased chances of comorbidity	ADHD anxiety mood disorders	Biological	Altered androgen – hormone related to aggression Differences in frontal brain activation Under arousal of ANS – seek arousing situations
						Psychological	Difficult **temperament** problem with understanding social cues such as facial expressions
						Social	** **greatest emphasis = Parenting practices** – punitive, critical restive controlling parents Coercive Processes model – helping people unlock the cycle of instruction leading to tantrum – leading to giving in – reinforcing tantrum (a cycle of conflict and coercion)
Conduct Disorder	Disorder marked by chronic disregard for the rights of others including specific behaviour such as stealing, lying and engaging in acts of violence						
	3% across childhood up to 6% in adolescence (13-18y)	More common in boys than girls	Early onset (boy only) before 11 years and late onset 11+ years	3 group in adolescence Not antisocial Late onset – experimenters Persistence group – early onset persisting into adulthood	ODD and ADHD in childhood often precursor of CD in adolescence	Biological	**Genes -** common genetic element between ODD, CD and ADHD **Low cortisol & high androgen** = aggression **Pharmacological approach**
						Psychological	Temperament characteristics – negativity, volatility and low persistence. Callous unemotional personality traits linked to development and severity of CD – lack of guilt, remorse or empathy ODD in childhood can act as warning and intervention can be used preventatively **Interventions** – Cognitive based interventions – child focused approach - - develop social and problem solving skills

This document is available on studocu

Downloaded by moin khan (moinamb99@gmail.com)

Kids in low SES setting are reinforced for showing anger	But encourage to hide feelings of sadness and worry	So you need to consider the overall context		Social	Poor social skills, associating with antisocial peers and peer rejections contribute to CD Family structure (single parent) family relationships (marital conflict) and parenting style (less warm, less supervision harsher discipline) **Interventions** - improve parenting skills and family relationships (parenting interventions, attachment-based approaches family therapy and school based approaches)

Separation Anxiety Disorder

	prevalence	**Gender difference**	**Onset**	**Progression**	**Comorbidity**	**Aetiology & treatment Biopsychosocial**	
Separation anxiety disorder	Disorder of childhood characterised by abnormal fear or worry over becoming separated from one's caregivers as well as clinging behaviour in the presence of caregivers						
	Very low in pre-schoolers but 4% of 7-9 year olds	More girls than boys	More common in mid childhood 7-9 years	Tends to improve over time but where it persists comorbidity becomes common	Depression anxiety & ODD to reduce chance of separation	Biological	**Genes -** genetic vulnerability to anxiety may be more common in girls (termed behavioural inhibition) **Pharmacological approach** - limited evidence
						Psychological	**CBT** – key approach – psychoeducation, exposure, coping skills training and reinforcement
						Social	Modelling parental anxiety, parenting behaviour and family conflict Attachment insecurity and parental absence Parents may "reward" behaviour with added attention and comfort (over protective)
Selective mutism	Disorder characterised by persistent failure to speak in certain setting even though the individual has the ability to speak (at least a month after the being of school term)						
	<1% though under-reported as kids are not disruptive	More girls than boys	Gradual onset, some have short term some for many years	Resistant to treatment	98% experience a comorbidity 75% have anxiety dis such as separation anxiety disorder or social phobia 40% elimination disorders	Biological	70% of parents have social phobia **Pharmacotherapy:** -may be of benefit in resistant cases
						Psychological	Anxiety May be linked to early psychological or physical trauma Link to shy inhibited temperament – similarity social phobia ****Behavioural intervention** – remove all reinforcement of mutism while bolstering self-confidence and decreasing anxiety. Exposure, self-modelling through video recordings (record parent asking a serious of questions answered by the child, record the teacher asking same questions and stick the two videos together
						Social	Shy parents may not seek treatment for kids

351. What us unuresis?

Enuresis	Elimination disorder in children who are at least five years of age who wet the bed or their clothes at least twice a week for three months, absence of organic cause Primary enuresis – never been dry Secondary enuresis – there has been a dry patch 6 month previously						
	15-22% 7yr boys 2.5% girls 7-15% boys 6% girls 8-11yr	More common in boy than girls	Should have sufficient control to be dry at night at age 5	15% spontaneous resolution rate per years – most grow out of it rate in adulthood	Highly comorbid with ADHD	Biological	43% MZ concordance rate 19% DZ, 44% if parent had enuresis 77% if both Shorter/later develop/hyperactive PSNS/ abnormal sleep patterns/ vasopressin
						Psychological	Specific psychosocial event implicated / Conditioning training better than drugs
						Social	Stressful life events – divorce death trauma Social isolation

Downloaded by moin khan (moinamb99@gmail.com)

Lecture 14 Ageing

352.Describe the epidemiology of ageing

The population is ageing like never before. The 85+ age group is the fastest growing population group, both due to high post WWII birth-rates (the baby boomers) and medical improvements. By the year 2051 25% of the population will be over 65 years of age, and 500000 of these people will have dementia.

91% of people over 65 years live in a private dwelling, with 40% of those 65-69 and 60% of those 80-85 years reporting disability, which is mostly a result of chronic lifestyle illnesses (CVD, diabetes, cancer). LE for males79 females 84.

353. What is the difference between primary and secondary ageing?

Primary ageing refers to the simple and fairly universal effects of biological ageing, as a result of the passing of chronological time. Examples being wrinkles, loss of muscle mass, slowing of physical prowess and others. (Physical, sensory & cognitive). Secondary ageing can be seen as abnormal ageing including disease states that you do not have automatically just because you are old, dementia for example is not part of "normal" primary ageing.

354. What is healthy ageing?

Healthy ageing or positive ageing occurs as a result of lifestyle changes that attempt to slow primary ageing and prevent secondary ageing

355. What are the age related declines that occur in movement, attention and information processing (and where possible how they can be improved using methodical advances to slow primary ageing)?

i. Voluntary movement – becomes slower and less co-ordinated, decline in balance, fine motor control and gait. (tDCS delivered to the primary motor cortex improves motor learning in older adults with affects lasting until the next day - consolidation)
ii. Attention – age related decline in task switching (multitasking) and planning
iii. Information processing – speed of information processing declines and effort increases.
iv. Memory- decline in episodic, semantic and working memory, with greatest declines observed in episodic memory (we know that when a memory is reactivated it is strengthen on reconsolidation, however this can be enhanced with tDCS to the PFC and while the effect isn't immediate following reconsolidation, on day 3 and day 30, the memory is strengthened)

356. What two areas remain unaffected by ageing?

i. Language does not decline and learning a second language can be used as a tool to delay cognitive decline
ii. Emotion –no decline in emotional regulation - depression and anxiety decline and wellbeing increases

357. What changes are seen in the following cognitive functions with age?

Attention = complex attention processes, such as switching between tasks are most affected by age, possible due to reduced cerebral blood flow to the frontal lobes

Memory = semantic memory is more resistant to ageing than episodic memory. For prospective memory (remembering to remember) time based tasks (take tablet at 2pm) are less well remembered than event based task (take tablets at lunchtime)

Language = most robust cognitive skill in face of ageing

358. What are Cohen's four stages in mature and later life

i. Midlife re-evaluation – quest to reconsider life and make it more rewarding (40-60 years)
ii. Liberation – yearning to experiment (60-early 70's), no longer worrying what people with think about life decisions
iii. Summing up – life review and search for greater meaning and giving back (70+)
iv. Encore – taking care of unfinished business, make a final contribution (80+)

This document is available on studocu

Downloaded by moin khan (moinamb99@gmail.com)

359. When comparing longitudinal and cross-sectional studies of ageing:

a) longitudinal studies are more reliable in establishing changes due to ageing☺
~~b) cross-sectional studies are more reliable in establishing changes due to ageing.~~
~~c) longitudinal and cross-sectional studies are equally reliable in establishing changes due to ageing.~~
~~d) cross-sectional more affected dropping out over time.~~
~~e) None of the given options are correct.~~

360. In general emotional states:

a) generally improve with increasing age. ☺
~~b) generally worsen with increasing age.~~
~~c) do not change across the lifespan.~~
~~d) generally worsen but only for women.~~
~~e) generally worsen but only for men.~~

361. The most common causes of death in the early 1900s and now are:

~~a) acute illnesses.~~
~~b) chronic illnesses.~~
~~c) chronic illnesses in the early 1900s, acute illnesses now.~~
d) acute illnesses in the early 1900s, chronic illnesses now. ☺
~~e) acute illnesses in both the early 1900s and now~~

362. With respect to age-related changes in cognitive functioning, which of the following is true?

a) Fluid intelligence declines in the third or fourth decade; crystallised intelligence does not decline significantly. ☺
~~b) Crystallised intelligence declines in the third or fourth decade; fluid intelligence does not decline significantly.~~
~~c) Both fluid and crystallised intelligence improve with age.~~
~~d) Both fluid and crystallised intelligence decline with age.~~
~~e) There are no age-related changes in either fluid or crystallised intelligence.~~

363. A centenarian is:

~~a) someone born this century.~~
b) someone aged 100 years or more. ☺
~~c) someone aged 65 years or more.~~
~~d) a specialist in older people's health.~~
~~e) None of the given options are correct.~~

364. A 2000 study reported a prevalence rate of _____ per cent for anxiety disorders in Australians over 65 years of age.

~~a) 1~~
~~b) 2.5~~
c) 4.5 ☺
~~d) 6~~
~~e) 8~~

365. Which is not one of Cohen's four stages in mature and later life?

a) mid-life re-evaluation
b) liberation stage
c) summing-up phase

372. Compared to people with Alzheimer's disease, those with vascular dementia more likely to have:

a) memory impairment as a central feature.
b) declines in social and occupational functioning.
c) a gradual rather than a sudden onset of the illness.
d) focal neurological signs, such as weakness or gait problems. ☺
e) none of the given options.

373. Of these psychiatric syndromes of older people, the most common syndrome is:

a) dementia. 5.3-7.6% ☺
~~b) depression. 1.1%~~
~~c) anxiety. 4.5%~~
~~d) schizophrenia.~~
e) ~~bipolar disorder~~.

374. One way of differentiating depression from a normal grief reaction is that people with depression are more likely to:

~~a) feel sad.~~
~~b) have problems with sleep and appetite.~~
c) have feelings of worthlessness and pervasive guilt or hopelessness. ☺
~~d) All of the given options are correct.~~
~~e) None of the given options are correct.~~

375. Older adults with anxiety tend to present with what sort of symptoms?

a) agitation
b) memory loss
c) sleep disturbance
d) more vegetative symptoms
e) All of the given options are correct☺

376. One of the most notable changes in the DSM-5 is the suggestion to replace the term 'dementia' with:

~~a) age-related cognitive decline.~~
b) major or mild neurocognitive disorders☺
~~c) Alzheimer's disease.~~
~~d) frontotemporal disorders.~~
e) ~~None of the given options are correct~~.

377. Compared to Alzheimer's disease, vascular dementia:

a) has a more sudden onset.
b) is associated with vascular disease risk factors and focal neurological symptoms.
c) generally involves better preserved memory.
d) All of the given options are correct. ☺
~~e) None of the given options are correct.~~

378. In the treatment of Alzheimer's disease, medication:

~~a) has no effect.~~
~~b) results in a complete cure.~~
c) improves cognitive functions. ☺
~~d) hastens the progression of the disease.~~
~~e) None of the given options are correct~~

Downloaded by moin khan (moinamb99@gmail.com)

d) ~~contemplation phase~~ ☺
e) encore phase

366. Memory lapses can be caused by:
a) normal ageing.
b) dementia.
c) ~~autism.~~
d) both normal ageing and dementia. ☺
e) ~~None of the given options are correct.~~

367. In terms of social support in later life, research indicates that:
a) older men receive less support than older women. ☺
b) ~~older men give more social support than women.~~
c) ~~men and women receive equal amounts of social support.~~
d) ~~All of the given options are correct.~~
e) ~~None of the given options are correct.~~

368. People gain most benefit from social networks when:
a) ~~their social networks are largest.~~
b) ~~their social networks are smallest.~~
c) the perceived amount of social support is greatest. ☺
d) ~~All of the given options are correct.~~
e) ~~None of the given options are correct.~~

369. In studies where age-dependent risk factors for anxiety and depression (e.g., gender, marital status, level of education and employment status) were controlled, there is a consistent pattern of:
a) decreasing risk of depression or anxiety with increasing age. ☺
b) ~~increasing risk of depression or anxiety with increasing age.~~
c) ~~no changes in risk of depression or anxiety with increasing age.~~
d) ~~increasing risk of depression, but decreasing risk of anxiety.~~
e) ~~increasing risk of anxiety, but decreasing risk of depression~~

370. Which of the following is not a strategy used by successful retirees according to Baltes(1999)?
a) selection
b) optimisation
c) compensation
d) distancing ☺
e) None of the given options are correct.

371. Compared with other older people still in the workforce, retirees have been found to:
a) ~~experience more negative affect.~~
b) be less anxious and depressed. ☺
c) ~~be more anxious and depressed.~~
d) ~~be equally anxious and depressed.~~
e) ~~None of the given options are correct.~~

379. Mild cognitive impairment:
a) ~~meets the criteria for the diagnosis of dementia.~~ (no as it may or may not progress to major NCD = dementia)
b) ~~only involves memory problems and memory complaints.~~
c) involves impairment of a range of cognitive functions including memory. ☺
d) ~~never progresses to Alzheimer's disease.~~
e) ~~always progresses to Alzheimer's disease.~~

380. Among psychiatric syndromes of older people, the syndrome with the greatest suicide risk is:
a) ~~dementia.~~
b) ~~bipolar disorder.~~
c) ~~a single episode of unipolar depression with psychotic features.~~
d) a single episode of unipolar depression without psychotic features. ☺
e) ~~generalised anxiety disorder~~

381. Common reasons why older adults might cease driving a car include all of the following except:
a) fear of having an accident☺
b) medications that interfere with attention and concentration.
c) sleep disturbances that might interfere with attention and concentration.
d) health-related symptoms (e.g., arthritis).
e) neurological conditions.

382. Factors that predict positive retirement include all of the following except:
a) higher income.
b) ~~part-time employment~~. ☺
c) being in a relationship.
d) having a choice in the timing of retirement.
e) All of the given options are correct.

383. Recent research shows that, on average:
a) retirement is generally a positive transition for both men and women. ☺
b) ~~retirement is generally a negative transition.~~
c) ~~retirement is generally a positive experience but only for men.~~
d) ~~retirement is generally a negative experience but only for men.~~
e) ~~retirement is generally a positive experience but only for women~~

TWO OF THESE ARE WRONG!!

384. How are symptoms of anxiety different among older and younger adults?
Older adults more often complain of cognitive complaints (memory and attention) and vegetative symptoms (poor sleep and appetite). Symptoms mimic those of medical conditions and drug side effects (shortness of breath and heart palpitations) leading to underdiagnoses

385. What cognitive skill improve with age?

This document is available on studocu
Downloaded by moin khan (moinamb99@gmail.com)

Wisdom, the expert knowledge and judgement about important difficult or uncertain questions encountered during life, is seen to increase with age.

386. What is the "selective pruning" that occurs social networks in later life?

Older adults are as satisfied with their social relationship, if not more so, than younger people. In later life people to increase the quality of social interactions and reduce the quantity, discarding unsatisfying relationships and investing in important connections.

387. Perceived amount of social support has been found to best predicts outcomes of satisfaction with one relationships. What kind to support do people receive and what gender differences have been observed?

- People receive two type of social support, Instrumental (practical support such as a lift to an appointment) and emotional (or affective = sharing points of view and deriving comfort) support. Over time while emotional support received remains stable instrumental support increases. Greater social support predicts better mental health outcomes ad may reduce AD risk.
- While women have greater social support networks this comes at the price of needing to provide support in return, while men give and receive less social support and report greater satisfaction with their interactions.
- For both genders, poor mental health and sensory impairments are associated with smaller social support networks and lower satisfaction with social support network.
- People would rather give than receive help and failing to allow older people to return a favour is demeaning and fails to recognise the importance of social exchange at all stages of the lifespan.

388. What is the difference between the way in which Erikson and Costa & McCrae's approaches to personality in ageing differ?

While Erikson emphasises change, with different personality themes at different stages of life and the need to resolve opposing tendencies (generativity versus self-absorption in midlife and integrity versus despair in later life), Costa & McCrae big five model of personality (the broad traits of personality) emphasises stability of temperament over adult life.

389. What has been found about wellbeing and life satisfaction over the lifespan?

Wellbeing and life satisfaction have been found to increase with age, with wellbeing defined as a person's general appraisal of his/her life "(global wellbeing") as well as his/her positive or negative affective state (or "hedonic wellbeing"). Hedonic wellbeing displays distinctly different patterns, stress and anger decline sharply from early 20's, worry is noticeable in middle age and then declines and sadness remains essentially flat.

390. To receive a diagnosis of mild neurocognitive disorder what symptoms must be displayed?

i. Cognitive changes that negatively affect functioning
ii. Must be observable by the individual, others or an objective cognitive test.
iii. The individual must engage in compensation strategies to help maintain independence and perform the activities of daily life

391. To receive a diagnosis of major neurocognitive disorder what symptoms must be displayed?

Major neurocognitive disorder (previously dementia) diagnosis requires a substantial level of cognitive decline (2 SD from previous functioning) and must interfere with independence.

392. What treatment strategies can be applied for older adults with depression and anxiety?

For depression CBT and interpersonal therapy is supported for the treatment of older adults in combination with antidepressant medication. Medication is not recommended for anxiety sufferers due to increased falls side effects etc (CARE: anxiety presentation often mimics benzo side effects, careful diagnosis required)

393. Why is it advantageous to diagnose dementia (neurocognitive disorder) early in the course of the disease?

Downloaded by moin khan (moinamb99@gmail.com)

While difficult to assess mild neurocognitive disorder may or may not progress to major neurocognitive disorder (dementia) but an early diagnosis means improved access to assistance and early interventions.

394. Are their lifestyle changes that could help lower your risk of dementia? DEAL

This document is available on studocu

Downloaded by moin khan (moinamb99@gmail.com)

Alzheimer's Disease Most common form of dementia – typified by ABeta neuritic plaque and neurofibrillary tangles (Tau proteins) in the extra cellular space of the cerebral cortex, hippocampus another forebrain structures

Prevalence	Age of onset	Gender difference	Mortality
5.3-7.6% of people aged over 65 in Australia (increasing to 500000 by 2040) + indigenous Australians who are at 5.2x the rate of average Australian	Age of onset typically 65	Women are at greater risk than men even controlling for longer life Expectancy Vascular dementia is the reverse	death in 8-10 years

DSM-5: Criteria Diagnosis requires aphasia (language disturbance) or apraxia (motor act impairment) or agnosia (failure to recognise objects or people) or executive function impairment

Progression Increasing cog dysfunction - remembering new information- - language (naming object people & places) - Personality & emotion- apathy agitation wandering aggression - toileting problems

Comorbidity	Dysfunction
➢ 16-70% delusions (36%) ➢ 4-76% hallucinations (23%) ➢ CVD ➢ Late onset depression Increases AD risk	➢ Nuns found to have plaques and tangles were more likely to develop dementia if they had cerebrovascular disease ➢ Caregivers prone to depression and anxiety

	Aetiology	Treatment
Bio	**Rule out** -physical disorders such as brain tumours **Predisposing Factors (vulnerabilities):** ➢ **Genes:** 308 genes implicated with only ApoE considered susceptibility factors40-60% of AD patients carry the gene **Precipitating factors (Stressors):** ➢ Plaques and tangles not enough to cause the condition to manifest	➢ **Pharmacology:** acetylcholinesterase inhibitors – inhibiting reuptake of ACh which is often depleted in in dementia – symptomatic relief not curative ➢ Research is ongoing into stimulation for immune cells to destroy ABeta plaques
Psycho	**Rule out** cognitive decline caused by depression or other mental disorders	➢ Psychological and behavioural interventions can be used to address behavioural and psychological symptoms of dementia (BPSD) -physical aggression leading cause of institutionalisation ➢ Monitoring BPSD is critical as lashing out might be the only way patient can indicate they are in pain for example ➢ Address wandering by minimising movement restriction, ensuring the patients use their retained skills and abilities and provide physical and emotional comfort
Social	**Predisposing Factors (vulnerabilities):** Epigenetic perspective – gene environment interactions	➢ Modify environment so not as frightening and engaging activities to avoid boredom and frustration Combined interventions for caretaker stress reduction and improving the relationship with patient Patients abused by caregivers were more likely to display aggression in return. ➢ Communication and coping strategies for caregivers

Downloaded by moin khan (moinamb99@gmail.com)

This document is available on studocu

Downloaded by moin khan (moinamb99@gmail.com)

395. How did Kaptein and Weinman define health psychology on 2004?

Kaptein and Weinman defined "health behaviour" as activities that may help to **prevent** disease, **detect** disease and disability at an early stage, **promote** and enhance health or **protect** from risk of injury".

The WHO organisation defines "health" as a state of complete physical, social and spiritual wellbeing, not simply the absence of illness"

396. What do we know about the epidemiology comorbidity of mental health disorders and their relation to physical disorders?

In 2007, 1.4 million or 38% of people with a disorder had two or more 12-month mental disorders. A mix of affective and anxiety disorders was the most common combination. LECTURE SAYS **25-40%.**

Having multiple mental disorders is associated with greater impairment, higher risk of suicidal behaviour and greater use of health services.

11.7% of people have comorbidity of a mental disorder and physical condition = **8.9% males and 14.5% of females.** Females **1.6x** more likely than males to have had physical and mental health comorbidity in previous 12-months.

However, stats may not be accurate as men are less likely to seek help for mental or physical conditions!!!

397. **What lifestyle factors improve health? –** many leading causes of death could be modified buy health behaviour

Diet -nutrient dense diet

Attitude – Injury prevention & OHS factors, road safety inc. seat belts, sexual health (AIDS), treatment compliance

Lifestyle -physical and cognitive activity

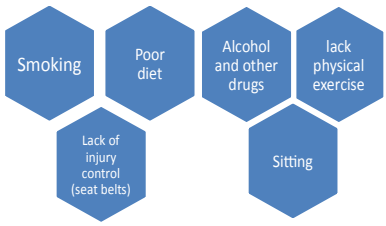
Environment – toxins including alcohol, tobacco and other drugs

398. What is the common element in social cognition models?

Social cognition models explain why people behave in healthy or unhealthy ways based on their **beliefs** (social cognitions), which can be seen to be relatively stable/enduring, shared within social groups, open to change and influential on behaviour (*" smoking isn't that bad for me, it helps me relax and I probably won't get cancer my grandpa lived to 90 and he smoked").*Models have been found to predict *intention* but fail to predict *actual behaviour*= the intention behaviour gap

399. Name the top 10 leading causes of death in high-income countries and behavioural and lifestyle factors are linked to the leading causes of death?

i. Ischemic Heart disease
ii. Stroke- CereVD
iii. Lung cancer
iv. Alzheimer's and other dementias
v. Lower respiratory infections
vi. Chronic obstructive pulmonary disease
vii. Colo rectal cancer
viii. Diabetes mellitus
ix. Hypertensive heart disease
x. Breast cancer



Downloaded by moin khan (moinamb99@gmail.com)

400. The Health Belief Model suggests that people's health-related behaviours are influenced by:

a) how susceptible they believe they are to a given illness or injury.
b) how severe they believe a given illness or injury would be.
c) the perceived benefits of, and barriers to, a health-related behaviour.
d) All of the given options are correct. ☺
e) None of the given options are correct.

401. Which of these statements is not true of the Health Belief Model? ****IMPORTANT***

a) ~~It explains most of the variance in people's health-related behaviours~~. ☺ it explains a limited proportion
b) Its variables are difficult to operationalise and test.
c) Interactions of variables in the model are not well described or defined.
d) Some of the central variables fail to predict some health-related behaviours.
e) assumes that people are rational decision makers and this is not often the case!!
f) Doesn't explain why people do the things they do
g) Predicts breast self-examination
h) All of the given options are true of the Health Belief Model.

402. Ajzen's Theory of Planned Behaviour suggests that an individual's intentions to perform a behaviour (e.g., quit smoking) are influenced by:

a) their attitudes to the behaviour and to the likely consequences.
b) their perceptions of significant others' beliefs and wishes concerning the behaviour.
c) their beliefs about how easy or difficult the behaviour may be to perform. (locus of control and self-efficacy)
d) All of the given options are correct. ☺
e) None of the given options are correct.

403. Describe Prochaska and Di Clemente's Stages of Change model

Prochaska et al.'s Stages of Change model shows that change does not occur in the linear "all-or-none" process but is instead involves a spiral pattern with occasional reversals. Though it lacks empirical support it is favoured by clinicians and researchers.

Stage 1: *precontemplation stage* (not ready for change) ambivalent but the seeds of change may grow. The therapist needs to develop of reason for change. (pros<cons)

Stage 2: *Contemplation stage (*getting ready for change) – aware of the problem but making no commitments. Therapist needs to use motivational interviewing to build a case for change and create a sense of discrepancy between life without change and how one wants one's life to be. (Pros=Cons)

Stage 3: *Preparation/determination* (ready to change and start taking action) – take small steps towards changing behaviour. Therapist should assist with goal setting and action plan support. Praise the decision, prioritise behaviour changes and develop vision, identify and assist in problem solving, start small and identify social support.(Pros>Cons)

Stage 4: Action, modifying behaviours in order to overcome problems for a period, adopting a drug free lifestyle from 1 day

Stage 6 – Termination – well entrenched second nature

Relapse (though the word is never used)= returning to old behaviour. Slips and set backs are part of learning

Doesn't always predict outcomes
People don't always fit neatly into one stage
"readiness to change" may be more useful notion

This document is available on studocu

Downloaded by moin khan (moinamb99@gmail.com)

to 6 months. Therapist helps develop problem solving and goal setting skills to prevent relapse while affirming and reinforcing change.

Stage 5: Maintenance beyond six months working to maintain abstinence with emphasis on social support, praising efforts and enhancing self-efficacy

404. What are the three ways in which stress can be defined?

Stress can be defined in three ways, with each definition resulting in a different method for measuring stress and different hypothesis concerning the influence it may have on health.

i. External stimulus: an event external to the individual & life events ("*so many stressful things have happened to me").*
ii. A physical or biological reaction ("*my heart is beating so fast"."I can't sleep").*
iii. A psychological state where the individual perceives that his/her coping resources are insufficient to meet the demands of a stressor/ burnout== (*"I feel overwhelmed I can't cope")*

405. Is stress likely to be a strong factor in determining health and illness?

Stress has been found to account for a relatively small percentage of variance in most health outcomes explained by stress, except for IBS where a strong relationship has been found. Stress has an influence on immune system functioning (think about cancer, chronic respiratory infections & AIDS), sympathetic nervous system activation (blood pressure, release of fatty acids into blood stream, release of catecholamine's increases stickiness of blood), stress and negative emotions amplifies the experience of pain

406. What is the relationship between stressful life events and psychopathology?

People experiencing depression are 2.5x times more likely to have experienced stressful life events and 80% of depressive episodes are preceded by a stressful life event

407. What were the coping styles proposed by Lazarus and Folkman and which is thought to be the most adaptive?

Lazarus ad Folkman propose two styles of coping :

a. Problem focus coping – taking action to solve the problem (more helpful when something can be done)
b. Emotion-focused coping – changing the way you think or act to "feel better", talking to friends and reframing (more helpful when the situation cannot be altered)

408. Describe the sequence described by Selye as the general adaptation syndrome (GAS)

ALARM*RESISTANCE***EXHAUSTION***
Sustained stress begins with *alarm*, the response to immediate danger or threat, which if persistent results in passing into the *resistance* stage, in which coping mechanisms are mobilised and if the stress is too intense or long lasting we move into *exhaustion* which can result in permanent damage and death.

409. What is stress?

Stress is the physiological response of the individual to a stressor. As first described by Seyle, stress is either "distress" which is an unpleasant physiological response or "eustress" which has also been called "good stress" as a result of a pleasant stimulus. The definition can vary enormously from one individual to anther depending on their response to the stressor, public speaking for example may be a joy to some and torture to another.

410. Physiology is profoundly influenced by what 2 factors related to stress, and why?

Downloaded by moin khan (moinamb99@gmail.com)

The impact of stress on physiology influenced by both psychological and social factors, with self-efficacy, your belief in your ability to cope, and social support factors that help mitigate the long-term effects of stress.

411. Discuss the hypothalamic pituitary axis and stress

The hypothalamic–pituitary–adrenal axis (HPA axis or HTPA axis) is a complex set of direct influences and feedback interactions amongst the hypothalamus, the pituitary gland, and the adrenal (also called "suprarenal") glands (small, conical organs on top of the kidneys).

Stress activates the HPA axis resulting in increased cortisol circulation, which in the closely related limbic system acts to close the feedback loop with the hippocampus shutting of the stress response. However increased cortisol levels may also kill hippocampal nerve cells.

If the hippocampus fails to respond to the cortisol, and thereby shut down the stress response the ability to turn of stress is reduced leading to further ageing and degeneration of the hippocampus.

Chronic stress can therefore lead to changes in physical function, including brain damage, and also has weakens the immune response.

The key elements of the HPA axis are:

The paraventricular nucleus of the hypothalamus, which contains neuroendocrine neurons that synthesize and secrete vasopressin and corticotropin-releasing factor (CRF). These two peptides regulate:

The anterior lobe of the pituitary gland. In particular, CRF and vasopressin stimulate the secretion of adrenocorticotropic hormone (ACTH). ACTH in turn acts on:

the adrenal cortex, which produces glucocorticoid hormones (mainly cortisol in humans) in response to stimulation by ACTH. Glucocorticoids in turn act back on the hypothalamus and pituitary (to suppress CRH and ACTH production) in a negative feedback cycle with the hippocampus closing the loop and ending the stress response (ideally) in the presence of cortisol.

Basic HPA axis summary (corticotropin-releasing hormone=CRH, adrenocorticotropic hormone=ACTH).

412. Research suggests that in situations where it is possible for something to be done:

a) ~~emotion-focused coping is more adaptive than problem-focused coping~~.
b) problem-focused coping is more adaptive than emotion-focused coping. ☺
c) ~~both problem-based and emotion-based coping are effective, and equally so.~~
d) ~~neither problem-based nor emotion-based coping is effective.~~
e) ~~social-focused coping is more effective than either problem-based or emotion-based coping~~.

413. Which component of Protection Motivation Theory is the strongest predictor of health-related behaviour?

a) ~~appraisal of threat~~
b) coping appraisal ☺
c) ~~self-efficacy~~
d) ~~high anxiety~~
e) ~~health knowledge~~

423. The Prochaska and di Clemente Stages of Change Model suggests that:

a) ~~relapse cannot occur until treatment has successfully been completed.~~
b) ~~the same strategy will always work for the same client.~~
c) different strategies are needed at different stages. ☺
d) ~~motivation and readiness for change do not affect outcomes.~~
e) ~~All of the given options are correct~~.

424. Patients may choose active treatment options rather than a 'wait and see' or palliative approach when outcomes are described in terms of:

a) relative rather than absolute risk reductions. ☺
b) ~~absolute rather than relative risk reductions.~~
c) ~~both relative and absolute risk reductions.~~
d) ~~neither relative nor absolute risk reductions.~~
e) ~~The way treatment options are described makes no difference.~~

425. The term 'stress' is used to refer to:

This document is available on studocu

Downloaded by moin khan (moinamb99@gmail.com)

414. In a recent study of factors related to bowel cancer screening in a regional Australian community, greater embarrassment in regards to bowel cancer screening was associated with which of the following?

a) ~~being at a later stage of change~~
b) ~~higher likelihood of participating in bowel cancer screening~~
c) being at an earlier stage of change ☺ (P & D stages of change model)
d) ~~All of the given options are correct.~~
e) ~~None of the given options are correct.~~

415. Which of these constructs is not a component of shared decision making with regards to patient care?

a) ~~The doctor ensures the patient gets the best intervention(s).~~ ☺
b) The doctor and patient are simultaneously involved in all stages of decision making.
c) The doctor and patient exchange information.
d) There is mutual deliberation followed by agreement on the treatment to implement.
e) The family is involved in all medical decisions.

416. Health psychology interventions can be targeted at:

a) individual patients.
b) groups.
c) communities and populations.
d) All of the given options are correct. ☺
e) None of the given options is correct.

417. Because it is perceived more accurately, the best format for presenting risk information is:

a) ~~bar graphs.~~
b) ~~pie charts.~~
c) pictograms. ☺
d) ~~verbal description.~~
e) ~~All of the given options are equally effective in presenting risk information~~.

418. The Job Demands-Control Model of employee burnout proposes that burnout in increased by:

a) ~~total hours worked.~~
b) ~~greater job control.~~
c) excessive job demands. ☺
d) All of the given options are correct.
e) None of the given options are correct.

419. There is increasing research evidence that psychological distress and dysfunction can predispose people to developing diseases via:

a) ~~failing to take a positive attitude.~~
b) ~~negative visual imagery.~~
c) impaired immune functioning. ☺
d) All of the given options are correct.
e) None of the given options are correct.

420. The fight or flight response involves all of the following except:

a) elevated muscle tension.
b) rapid breathing.
c) elevated heart rate.
d) increased blood pressure.
e) ~~exhaustion.~~ ☺
a) a stimulus or event external to the individual.
b) a physical or biological reaction.
c) a psychological state or response.
d) All of the given options are correct. ☺
e) ~~None of the given options are correct~~.

426. Which of the following is not one of the four phases a person might experience response to illness according to Morse and Johnson (1991)?

a) uncertainty
b) disruption
c) striving for recovery
d) ~~maintenance of health~~ ☺
e) restoration of wellbeing (based on acceptance)

427. Which is <u>not</u> a typical physiological change associated with progressive muscle relaxation?

a) decreased oxygen consumption
b) decreased heart rate
c) ~~increased beta waves~~☺
d) decreased muscle tension
e) All of the given options are correct.

428. The strongest associations between stress and physical disease have been reported in the literature on:

a) ~~cancer.~~
b) irritable bowel syndrome. ☺
c) ~~asthma.~~
d) ~~coronary heart disease.~~
e) ~~arthritis.~~

429. A 2008 study conducted a meta-analysis of psychosocial interventions for cancer patients and concluded that:

a) the overall quality of studies in this area is poor.
b) the evidence is highly inconsistent.
c) many of the studies had low statistical power to detect effects of intervention.
d) All of the given options are correct. ☺
e) None of the given options are correct.

430. Which of these is a valid criticism of the research on mood disturbance or stress and subsequent cancer diagnoses?

a) Cancer symptoms may have preceded the reported stress or mood disturbance.
b) Sample sizes are often small.
c) Other risk factors and mediating social supports are not always controlled for.
d) All of the given options are correct. ☺
e) None of the given options are correct.

431. Research has demonstrated a relationship between coronary heart disease and:

a) ~~work stress.~~
b) depression and lack of social support. ☺
c) ~~type A behaviour.~~
d) All of the given options are correct.
e) None of the given options are correct.

432. The finding of some studies that people with advanced illness has been shown to have an

Downloaded by moin khan (moinamb99@gmail.com)

421. According to Self Regulation Theory, an individual's initial response to a health threat is based on their:

a) ~~cognitive representation of the illness.~~
b) ~~emotional representation of the illness.~~
c) cognitive & emotional representation of the illness. ☺
d) ~~stage of change: contemplation or pre-contemplation.~~
e) All of the given options are correct.

422. Which of these constructs is <u>not central</u> to Maslach's model of burnout?

a) ~~total hours of work~~ ☺
b) reduced personal accomplishment
c) depersonalisation
d) emotional exhaustion
e) All the options given are correct

equivalent quality of life to that of healthy people can be explained by which of the following phenomena?

a) ~~illness denial syndrome~~
b) response shift ☺
c) ~~social support equivalence~~
d) All of the given options are correct.
e) None of the given options are correct.

433. Which is <u>not</u> a key component of Acceptance and Commitment Therapy? (Think mindfulness)

a) acceptance of life circumstances (e.g., chronic pain) without attempting to change them
b) non-judgmental observance of thoughts
c) becoming aware of self
d) ~~correcting cognitive distortions~~ ☺ = CBT
e) None of the options given are correct.

Exam preparation

Approaching short answer questions:

- Biopsychosocial aetiology and treatment
- Take a lifespan perspective not a snap shot
- Symptoms are often a comment on a underlying problem..the anorexia sufferer didn't start out having a problem with 'food' it could have been anything that they fixated on it is simply the manifestation of that problem
- Heterogeneity of experience – same pathways do not necessarily lead to same places
- Distress/dysfunction/statistical rarity/norm violation
- The line between normal and abnormal is problematic to identify and is potentially a social construct and so there must be a respect for autonomy (independence/freedom)
- Comorbidity

Ethics

APS code of ethics - The Code is built on three general ethical principles. They are:

A. <u>Respect for the rights and dignity of people and peoples</u>: including the right to autonomy and justice	1. **Justice** - avoid and assist clients address discrimination, stereotyping and prejudice on any grounds 2. **Respect** – always communicate respect, either with client or other professionals and respect peoples legal and moral rights 3. **Informed consent** – keep clients fully informed, using plain language, nature, purpose, risks, consequences of declining a service, frequency, duration, cost, and obtain informed consent unless legal capacity is limited or impaired and then obtain consent from legal personal representative or authority but also attempt to gain consent from the client 4. **Privacy** – avoid invasion of privacy and collect only relevant information 5. **Confidentiality** – safeguard confidentiality
B. <u>Propriety</u> incorporates the principles of beneficence, non-	1. Competence – maintain skill and learning 2. Record keeping 3. Professional responsibility

This document is available on studocu

Downloaded by moin khan (moinamb99@gmail.com)

maleficence (including competence) and responsibility to clients, the profession and society.	4. Provision of psych services at the request of a 3rd party – all parties understand the nature of the relationship 5. Provision of psych services to multiple parties – everyone understand the limitations of the situation
C. **Integrity - reflects the need for psychologists to have good character and acknowledges the high level of trust intrinsic to their professional relationships, and impact of their conduct on** the reputation of the profession	1. Reputable behaviour – conduct reflects well upon the profession 2. Communication – honest, correct misinterpretations, never false or misleading 3. Conflict of interest 4. Financial arrangements

Underlying principals

1. Justice	avoid and assist clients address discrimination, stereotyping and prejudice on any grounds
2. According dignity	People have an innate right to be valued, respected, and to receive ethical treatment
3. Autonomy	the capacity of a rational individual to make an informed, un-coerced decision
4. Non maleficence	"First do no harm" given an existing problem, it may be better not to do something, or even to do nothing, than to risk causing more harm than good
5. Pursuit of excellence	Aim to be outstanding in your field and reflect well on the it (Competence – maintain skill and learning)
6. Beneficence	the doing of good; active goodness or kindness
7. Care and compassion	Respond to the suffering of others
8. Veracity	Honest and truthful
9. Fidelity	Faithfulness and loyalty – my word is my bond

National practice standards for the mental health workforce 2013

This revised set of standards is intended to strengthen the workforce and to outline the values, attitudes, knowledge and skills required when individual members of one of the five professions listed above work in a mental health service.

While interventions such as biological and psychological treatments are important, empathy, understanding and expert knowledge are critical to successful outcomes.

Ethics of dealing with kids

- Mandatory reporting
- Working with children check
- Informed consent =parent or guardian, mature minor, court order unless not in best interest of the child
- Avoid dual relationships – who is the client..school, child, parents own psychological care

Downloaded by moin khan (moinamb99@gmail.com)

This document is available on studocu

Downloaded by moin khan (moinamb99@gmail.com)